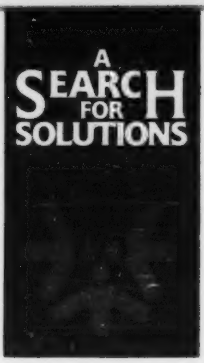
A SEARCH FOR SOLUTIONS

REPORT

OF THE TASK FORCE ON ALCOHOL AND DRUG ABUSE IN THE WORKPLACE

BRITISH COLUMBIA
SEPTEMBER, 1987

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THE TASK FORCE ON ALCOHOL AND DRUG ABUSE IN THE WORKPLACE

Honourable Peter Dueck
Minister of Health

Honourable Lyall Hanson
Minister of Labour and Consumer Services

We respectfully submit the report of the Task Force on Alcohol and Drug Abuse in the Workplace.

In the fall of 1986, the Task Force was appointed under the joint sponsorship of the Ministry of Health and the Workers' Compensation Board. Our purpose was to gather information about the extent and effect on performance of alcohol and other drugs in the workplace; to gauge their negative impact on occupational safety and health; and to recommend means of promoting the well-being of those affected by or at risk of developing alcohol and other drug-related difficulties.

During April and May, 1987, at hearings in 12 British Columbia communities, the panel heard 72 oral submissions and received 61 written submissions.

Drug impairment in the workplace cannot be considered in isolation from the situation in the community at large. The critical problem of alcohol and drug abuse throughout British Columbia is reflected to a significant degree in the workplace, resulting in safety hazards and lost productivity.

Existing treatment services need expansion and increased funding.

The Employee Assistance Program (EAP) concept provides an effective means of rehabilitating those whose job performance is affected by drug-related personal problems. An EAP responds to a human need with an offer of help - a humane response enhanced by the employment relationship.

The EAP concept is transferrable to communities beyond the workplace.

The Task Force recommends that: the EAP concept be extended to make its services available to all residents of the province whose task performance can deteriorate because of alcohol and other drug abuse or any severe personal problem; and that funding for the programs be raised through the sale of beverage alcohol.

The Liquor Policy Review Panel held hearings and published its report in June 1987. The Task Force independently arrived at similar recommendations in the areas of education, advertising and funding.

Implementation of the recommendations will benefit the chemically dependent, their immediate family, friends, industry and the community. Implementation will reduce health care costs.

September 23, 1987

James M. Ryan
Chairman

David J. Baker
Member

Robert H. Buckley
Member

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ACKNOWLEDGEMENTS

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INTRODUCTION

In the fall of 1986, a Task Force was appointed under the joint sponsorship of the Ministry of Health and the Workers' Compensation Board to:

- gather information about the nature, extent and effect of alcohol and other drugs on performance in the workplace;
- gauge the negative impact on occupational safety and health;
- recommend means to promote the well-being of people affected by or at risk of developing alcohol and other drug-related difficulties.

In preparation for provincial hearings the Task Force attended the four-day Western Conference on Alcohol and Drugs (WESCAD) in Vancouver and a one-day seminar with Dr. G. O'Connor, a recognized expert in the field of chemical dependency from California. The Task Force also visited six employee assistance programs on site: MacMillan Bloedel, B.C. Ferries, Canada Post, B.C. Rail, B.C. Tel, ILWU-BCMEA Waterfront Industry. The Task Force visited two residential treatment centres, Victoria Life Enrichment Society and Maple Ridge Treatment Centre.

The Task Force held formal hearings and informal "open house" meetings in the following communities: Courtenay, Nanaimo, Victoria, Kamloops, Williams Lake, Prince George, Fort St. John, Terrace, Cranbrook, Trail, Kelowna and Vancouver, April/May, 1987.

The Task Force heard 72 oral submissions and received 6l written submissions.

It was clear from the start the Task Force would not be able to consider the workplace in isolation from the community at large. Whatever occurs in the workplace is a reflection of social conditions outside the workplace. In addition, the definition of what constitutes a "workplace" varies between agencies. The home is the workplace of the homemaker; the school is the workplace of teachers and students. More practical is the concept of "task place". The Task Force found that the Employee Assistance Program principle of looking at task performance failure as a "window of opportunity" for intervention efforts was useful and applicable to all walks of life. Besides those specifically related to the Workers' Compensation Board of British Columbia, most efforts to combat the problem associated with mood-altering chemicals are general to the population and cannot be confined to the workplace.

The report of the Task Force is a poor vehicle to convey the emotional content of the subject at hand. The sorrow, humiliation, dejection and tragedy caused by alcohol and other drugs in our province was represented in vivid and moving terms by many presenters. The Task Force was constantly impressed by the integrity, dedication and wisdom of many of the people who were working in the field of chemical dependency in British Columbia. The Task Force was also constantly reminded of the joys and benefits produced by the recovery of people from these devastating disorders. One of the most touching examples was provided by the people of Alkalai Lake in a movie they made entitled "Honour of All". It is the story of a community devastated by the effects of alcoholism. Beginning with the recovery of one member, the community moved from a 98 percent alcoholism rate to a 90 percent recovery rate in a matter of a decade. The town of Alkalai Lake helped itself to recovery. Their success and inspiration made it obvious to the Task Force that solutions to the problem of chemical dependency could be found for other British Columbians.

The Task Force was convinced that the recovery of a single individual is likely to bring very positive benefits to their immediate family, friends, occupation and community. As a province we must have the

courage to face our problems with mood-altering chemicals honestly and to demonstrate a commitment to bringing about change. We must imitate the action and spirit of the people of Alkalai Lake.

> **No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if the manner of thy friends or of thine own were. Any man's death diminishes me, because I am involved in Mankind; And therefore, never send to know for whom the bell tolls; It tolls for thee.**
> **John Donne, Meditation #17, 1623 AD**

THE TASK FORCE ON ALCOHOL AND DRUG ABUSE IN THE WORKPLACE

EXECUTIVE SUMMARY

ALCOHOL AND DRUGS IN BRITISH COLUMBIA

The Common Drugs

Although there is widespread use of many drugs in the province including alcohol, cannabis and pharmaceuticals, alcohol presents by far the greatest problem. Cannabis, now being recognized as a dangerous drug, is the second most commonly used. Sedative hypnotics are also very common, the most widely prescribed being benzodiazepines (Valium family) which are often abused inadvertently.

Cocaine use is increasing rapidly, while narcotics comprise a relatively small usage compared to other drugs.

Poly-drug use (the mixing of drugs) produces an unpredictable synergistic effect rather than an additive effect. As an example: the use of alcohol while taking Valium may produce four times the intoxication one would expect when the drugs are used separately.

Use of alcohol and/or cannabis along with their drug of choice is the rule rather than the exception for most drug users.

Over the counter (non-prescription) drugs, including codeine-containing preparations, are widely used and misused.

Alcoholism and Other Addictive Disorders

Alcoholism is one of the most common illnesses in British Columbia. Ten percent of the adult population suffers from alcoholism.

> Alcoholism is a disease characterized by the repetitive and compulsive ingestion of any sedative drug, ethanol (alcohol) representing but one of this group, in such a way as to result in interference with some aspect of the [person's] life, be it health, marital status, career, interpersonal relationships, or other required societal adaptations. As with any other illness, alcoholism represents a disfunction or maladaption to the requirements of every-day life.

The illness process and recovery from the illness differ only in minor details from drug to drug.

All alcoholics at some time were social users - albeit briefly for some. Alcoholics do not move back to being social users; they are in need of intervention and treatment to help them become non-users. Non-users may need encouragement and support and they deserve positive reinforcement.

Social users represent the current population at risk for development of alcoholism.

The average age at which people first drink has dropped from 18 years to 14 years in the past 20 years. Alcoholism develops at an earlier age.

There is an increasing tendency to dual addiction.

Alcoholism is a chronic illness that affects people physically, mentally, emotionally and spiritually. Alcoholism is no respecter of social class, economic standing, race or gender.

Alcoholism masquerades as many other illnesses, resulting in a large percentage of health dollars being spent inappropriately and ineffectively.

Intoxicating the brain with alcohol or other drugs is like hitting it with a sledge hammer. That shows up as impairment of function. Loss of productivity, peculiar, inappropriate and dangerous behavior affect the worker, the co-workers, the employer and the worker's family. Each in turn will affect the community at large. Because of the complex nature of those interactions the total cost to the community is inestimable.

Hangovers can cause severe impairment of coordination, judgment and emotional state on the worksite.

The Family Illness

One of the earliest problem areas for the alcoholic is in family relationships. Treatment of the alcoholic alone without treating their family is unlikely to be successful.

The worker who has an alcoholic family member may be a hazard in the workplace because of emotional or mental impairment.

Denial

The major symptom and expression of alcoholism is denial of the problem by:

-the alcohol	-family members
-fellow workers	-society at large
-management	-union
-friends	-health care professional

Blaming job stress as the reason for drinking is a self-enabling form of denial. Although stressful worksites do exist, substance abuse must not be seen as the inevitable result of occupational stress but as an inappropriate response to stress, whatever its source.

> Alcohol and Drug Abuse in the workplace is a problem at every level, from the boardroom to the shop floor.
> **Bob Cunningham, Crows Nest Resources**

Denial in all its forms results in the alcoholics being "enabled" to continue in their illness.

Physicians enable the alcoholic by :
-failing to explore the issue of alcohol and drug use skilfully and persistently;
-failing to diagnose alcoholism when the signs and symptoms are obvious;
-prescribing mood altering drugs when it is known that the patient is chemically dependent.

The Treatable Illness

Chemical dependency is most amenable to treatment. As many as 8 out of 10 alcoholics can be helped. Few chronic, potentially fatal relapsing illnesses have that chance of recovery.

The Million Dollar Illness

An alcoholic, unchecked and untreated can cost the community one million dollars exclusive of property damage. An alcoholic can be effectively treated for one thousand dollars.

Extent of the Problem

The effects of alcohol and other drugs in the workplace and, indeed, the effects on society in general, are extremely difficult to quantify on a scientific statistical basis.

Alcohol and other drug related disorders are under-reported and under-diagnosed.

Ethical problems surround the collection of data in the field of alcohol and drug studies. Conclusive evidence regarding the use of alcohol and other drugs depends on laboratory analysis of bodily fluids. The very collection of these fluids imposes ethical difficulties for studies.

No legal mechanism exists for obtaining toxicology samples in non-fatal work injuries and therefore there are no data available that accurately reflect the role of alcohol or drugs in work-related injuries.

Despite the difficulties in collection of data, the Task Force was presented with many convincing statistics.

> **The negative results of alcohol consumption cost the province over two billion per annum, five times the amount earned through liquor sales.**

> Seventeen percent of the workforce consumes alcohol in amounts that put them in danger of developing a dependency.

Between 60 and 70 percent of the clientele at one outpatient clinic were employed. Less than five percent of alcoholics live on skid road.

A study at the Victoria General Hospital in 1985 demonstrated that 40 percent of male patients age 19 and over had demonstrable problems with their use of alcohol.

The changing patterns of drug use today will have a major effect on health care needs in the future. The high incidence of multiple drug disorders in young patients will result in increased demands on the existing system of care.

Between 70 and 80 percent of males serving time in our penal system were under the influence of alcohol at the time of the crime or alcohol was a significant contributing factor. In the first quarter of 1987 over 39 percent of those arrested for serious crime admitted drug use.

Fifty percent of clients treated at a Vancouver outpatient clinic in 1986 were found to have used cocaine.

Productivity

Impairment in the workplace, from whatever cause, will decrease productivity through increased absenteeism, accident costs, industrial relations costs and disruption of communication with supervisors, fellow workers and business associates.

Population Sub-Groups

Several population sub-groups received specific mention by presenters as having needs which are not being met in the present system of care. These include:

Children
Teachers
Seniors
Children of Alcoholics
Residents of Small Towns
The White Collar Worker
Youth
Women
The Working Poor
Employees of Small Business
Health Care Professionals

EMPLOYEE ASSISTANCE PROGRAMS (EAPs)

Employee Assistance Programs evolved from belief that treatment of the alcoholic could be made more cost effective than termination. Today's EAPs address all personal problems that can affect job performance. Their success is indicated by the ever-increasing number of firms adopting the concept.

EAPs are a process leading from the **identification** of a problem, through **intervention** to **assessment**, via **referral** to **treatment**. In a workplace the chain of events is triggered by unsatisfactory job performance. Identification and Intervention are the employer's responsibility; Assessment and Referral are functions requiring specialized knowledge and expertise; they can be provided through third party professionals. Treatment is provided through various community services.

A major British Columbia employer described the parameters of the problems: "Twenty percent of the workforce could benefit from some form of EAP service. Seven to 12 percent of employees have alcohol problems, a further three to five percent have difficulties with other drugs and an additional five to seven percent have emotional problems."

Identifying the troubled worker depends on having an awareness of the signs of alcohol or other drug impairment and by using that awareness in performance monitoring. The effective EAP includes a training component which alerts supervisors to the significance of the signs. The supervisor's awareness, coupled with active monitoring and documentation allow for early identification. This method is known as the performance model; its focus is limited to productivity and safety in the workplace. It does not deal with the issue of use away from work unless that use affects the job. The value of the model is that it allows management to intervene on the basis of legitimate performance expectations and to maintain union support while doing so.

Intervention is achieved through the use of constructive confrontation. Constructive confrontation involves creating a "bottom line" that motivates the employee to take the necessary steps toward treatment. It is most effective when there is an agreement between labour and management as to the "bottom line", which may include job termination or a suspension until recovered. The potential loss of job is a powerful motivator.

The assessment and referral functions are considered to be the key to an effective EAP, the intersection between the worksite and the community's health and social service systems. Assessment is required to identify prime problems so that treatment can be effective. It is futile to treat stress as the cause of unsatisfactory behaviour, if that stress is only a symptom of chemical dependency. The referral function becomes important after the prime problem has been identified. Should alcoholism be the prime problem it may be inappropriate to recommend six weeks in a live-in treatment centre if outpatient counselling could do the job just as well. A course of treatment is negotiated and a referral to treatment is made.

Involuntary treatment of an un-motivated alcoholic has been shown to be effective in many cases. Many so-called voluntary patients submit to treatment only as a way of coping with strong social pressure or other forms of coercion. Treatment results are believed to be equal for voluntary and involuntary patients.

Presenters throughout the province were consistent in claiming EAPs as the most effective means to combat alcohol and drug abuse in the workplace. Their message was that there should be more EAPs, and that some existing EAPs should become better. There are impediments to the maximum utilization of EAPs as an aid to the troubled workers of British Columbia: limited availability, quality control, multiple worksites, treatment resources, scope of program, on-site facilities, combined responsibilities, conflicting EAP duties, labour relations climate, lack of educational and promotional materials and the high cost of developing a program.

TREATMENT

Alcohol and Drug Programs

Most services pertaining to alcohol and other drugs in the province are provided by or funded through the Ministry of Health's Alcohol and Drug Programs (ADP).

In 1986 25,000 individuals used the 72 services that are funded directly or indirectly by the ADP.

The system provides a continuum of care through three components:

Detoxification Centres

- Provide safe environment for withdrawal from alcohol and other drugs.
- They require enhancement of existing centres
- where no facility exists local hospitals could, with appropriate training of staff, provide detoxification service and linkage to ADP system of care.

Outpatient Clinics

- The mainstay of the system of care and crucial to the success of the system, the clinics serve as a broker for services, perform assessment and referral functions and provide treatment through counselling and group work. The clinics are generally overloaded and understaffed and most have long waiting lists.
- Major enhancement is required.

Residential Treatment

- Provide a supportive environment post-detoxification (supportive recovery home) or intensive treatment courses (residential treatment centre).
- They need more services for youth, women.
- Careful study of services and costs is required, with emphasis on referral source needs.

The Medical Practitioner

Physicians, especially general practitioners, are in an ideal position to identify and intervene on behalf of the chemically dependent patient. However, they receive inadequate training in the subject; they are trained to diagnose and treat symptoms, not the illness itself, which often leads to the inappropriate prescription of mood-altering drugs.

Some physicians engage in collective denial of the problem in individuals.

Inadequate referral services can prevent doctors from obtaining appointments for patients for periods of up to five weeks.

Chemically-dependent people can be extremely difficult patients. Because of inadequate training in their handling, doctors find them time-consuming, frustrating and an impediment to the rest of their practice. If the patient is treated according to need, the present fee structure does not adequately recompense the physician.

Self-Help Groups

With AA as the prototype, these groups form an essential, invaluable resource for those whose lives are affected by chemical dependency:

Alcoholics Anonymous
Al-Anon Family Groups
Alateen
Narcotics Anonymous
Cocaine Anonymous
Adult Children of Alcoholics

The Task Force feels that an extremely important part of any professional service is ensuring that patients and their families become involved with the appropriate self-help group.

EDUCATION

There is an urgent need for additions to the public school curriculum relating to alcohol and drugs. This key element in prevention is scarcely being tapped. The curriculum must encourage critical thinking about advertisements aimed at youth, the consequences of alcohol and drug use and the benefits of positive lifestyle choices.

The academic message must be reinforced through the example of a visible policy on substance abuse consistently applied throughout the school system.

The objectives of the school program can be defined provincially but its implementation will require support and cooperation at the local community level.

Society's perception of mood-altering substances must be changed, through information programs (advertising, instruction courses etc.) on addiction, prevalence, effects on families and children and social costs.This will require a long term commitment, strong leadership and effective coordination.

The prime education message to management is two-fold: first, no organization is immune to alcohol and drug abuse by its employees; second, there is an effective way to manage the problem: the EAP process.

Unions must instruct their representatives that alcohol and other drugs have both short and long term dangers to their members. Casual use on the worksites cause impairment creating a safety hazard to self and others. Habitual use anywhere leads to addiction. Casual use on the worksite can be prevented through peer pressure. Chronic abuse can be treated through the EAP process.

There is no such thing as "social" use of alcohol or other drugs on the worksite, whether that site be the forest, the kitchen, the factory or the boardroom.

WORKERS' COMPENSATION BOARD

The abuse of alcohol and other drugs can have two possible effects on workers and their relations with the WCB. The first possibility is impairment, when that impairment is part of the contributing factors leading to an injury. The second occurs when alcohol and drug abuse impede recovery.

Multiple Injuries

Almost half of all claimants have had only one claim in their working lifetime. Three out of four have had three claims or less. Less than one out of five have had more than four claims.

Only four claimants out of a hundred have had more than 10 claims, yet these multiple injury workers are responsible for every fifth claim processed by the WCB. There are 45,188 workers in this minority group.

Multiple injury claimants are spread across several classifications. They appear in both high and low risk industries.

A worker does not accumulate a history of multiple claims because of bad luck. Multiple claims are the result of continuing unsafe conditions, habitual unsafe acts, constant unsafe procedures, or any long term combination. The causative factors may be occupational or personal.

Causative factors exist for all injuries. If the factors are occupational, the employer is responsible for corrective action. If no occupational causative factors are found, the possibility of personal factors must be suspected. The greater the number of personal injuries without occupational factors, the more certain it becomes that the causative factors are personal. The main personal causative factors are alcohol or other drug impairment, emotional or physical problems, or any combination.

Occupational factors can be eliminated or reduced through corrective action by the employer, perhaps in cooperation with, or at the direction of, officers of the WCB.

Personal factors can be eliminated or reduced through corrective action by the worker. Alcoholism, and other addictions, as well as emotional and physical problems, are all treatable illnesses or conditions.

Workers with a history of multiple claims will tend to continue having claims until corrective action is taken. A multiple claims worker is in a condition of undue hazard regardless of whether the prime causative factors are occupational or personal. A multiple claims worker is at risk and is in need of help. Intervention is required.

Delayed Recovery

A small percentage of claims account for a major proportion of total costs. Catastrophic injuries, such as severe burns, spinal cord injuries and lost limbs are not the major factor; their severity is more than offset by their low frequency. It is the minimal incident or injury that has a disproportionate disability and delayed recovery that generates the high cost.

Delayed recovery is often the result of psychological factors. There is a need for the physician to differentiate the physical and emotional problems and deal with each adequately. The WCB has recognized that "multiple problems" can be a factor in an injured worker's return to work:

> Where the injured worker is suffering from a work injury together with some other impediment to his return to work (e.g. alcoholism), rehabilitation assistance may sometimes be needed and provided to cover the whole problem.

The Task Force believes that the most common "multiple problems" are likely to be alcohol and other drug abuse, emotional problems as a prime disease, or as sequelae to alcoholism and addiction, and physical problems resulting from addiction.

An illness or condition must be identified before it can be treated.

Intervention

In an ideal situation, the worker with a history of multiple injuries and/or delayed recoveries would be employed by a company with an effective safety program and a "broad brush" employee assistance program. In this ideal situation, as a result of the accident investigation process or through analysis of the worker's overall safety record, the possibility of personal problems as causative factors would be considered and referrals made to the firm's EAP. Regardless of the nature of the personal problem or the method of entry into the program, qualified help would be available, the prime problem would be identified and treated. The worker would no longer be at risk; the worker would recover to maximum potential.

The Task Force suspects that relatively few multiple injury workers incurred their records of injuries while continuously employed by a firm with an effective safety program. It is more likely that most multiple injury workers have worked for different firms, sharing their injuries among them, with each new employer being unaware of the worker's injury history. In the alternative, if the multiple injury worker established his injury record entirely with one employer, it must be concluded that the employer does not "keep score" or, if records are kept, simply is not motivated to act. Without intervention the multiple injury worker remains at risk.

THE SOLUTIONS

The Task Force recommends that the EAP concept be extended to become available to all residents of the province.

The Employee Assistance Program concept has proved to be the most effective way to combat alcohol and drug abuse in the workplace.
It is recommended:

1.a) That the name of the Alcohol and Drug Programs (ADP) be changed to a more general title such as Community Assistance Program (CAP) and that the program be designated the following functions:

Assessment and referral service
Alcohol and drug programs (treatment function)
Prevention
Education
Research

Recommendation of the title "Community Assistance Program" is for the purpose of this report only.

Alcohol and Drug Programs is stigmatized by its name. The Task Force was convinced that ADP may be attracting fewer than half the clientele they could expect if the name were changed.

A supervisor must detect and document unsatisfactory work performance but is not in a position to diagnose the nature of the problem; but any referral to ADP - even for assessment - is a form of *de facto* diagnosis.

It is expected that a majority of assessments will confirm an underlying chemical dependency. ADP should remain as the nucleus of the proposed CAP.

Most of the assessment and referral services of CAP will be provided by contracted local agencies.

1.b) That CAP ensures that appropriate services are available to all citizens of British Columbia, regardless of location, gender, age, occupation or financial status.

CAP will provide an assessment, referral and treatment system to workers who do not have the benefits of an EAP.

Assessment and referral services must be made available to small communities and isolated communities through contracted local agencies.

Current programs must be modified to be more attractive to women and more sensitive to their needs and issues.

Children can be chemically dependent, posing increasing problems at home, at school and, ultimately, in the community at large. The Ministry of Education should develop a standard policy addressing chemical dependency in the school system, which would include a "student assistance program" for recognition and intervention. CAP will provide assessment and referral services for the students and their families and ensure that their needs are met in treatment.

CAP will provide services to meet the specific needs of the retired.

Inadequate personal financing must not be a barrier to treatment. CAP will address this by providing service outside of working hours and through the development of financial assistance.

1.c) That CAP have greatly enhanced research functions and capability.

There is a need for a coordinated and standardized collection of statistics on alcohol and drug use. Expert design of practical research projects is required. Information is essential for effective program development, policy and planning.

1.d) That CAP, in consultation with the relevant professional association and the Ministry

of Advanced Education and Job Training, develop standards for accreditation for those working in the field of chemical dependency.

Accreditation must be a prerequisite to becoming a contracted local CAP agency.

1.e) That CAP, with the medical profession, develop an accreditation process for physicians participating in the CAP process.

Physicians are an essential element of the CAP system. To participate, interested physicians will need to receive training. CAP, together with the University of British Columbia Faculty of Medicine must develop an accreditation process.

2. That the recommendation of the Liquor Policy Review, June 1987, concerning alcohol education of the Public Licensee and Server and at Primary, Secondary and Post-secondary schools be implemented and expanded to include other drugs.

3. That Fetal Alcohol Syndrome, a common cause of preventable mental retardation, be a prominent subject of continuing education of the public and of the health care professionals.

FAS has not received enough attention in either the lay or the medical press. The medical profession must ensure that adequate instruction regarding the dangers of alcohol ingestion to the unborn be given to all women of child-bearing potential.

4. That teachers be adequately trained in the recognition of the signs and symptoms of substance abuse and instructed in the proper process and procedure to follow for referring students for assistance.

5. That local school districts, in conjunction with their provincial association and in cooperation with employee organizations develop an Employee Assistance Program for teachers and other employees of public school districts.

6. a) That the Workers' Compensation Board develop a series of training programs on alcohol and other drugs emphasizing the techniques of identification of the chemical abuser through signs of use and symptoms of alcohol and other drug dependencies. Such programs should be specifically designed for the use of employers in fulfilling their obligations under Regulation 8.30.

6. b) That the Workers' Compensation Board adapt the Employee Assistance Program concept by establishing a Claimant Assistance Program to enable identification, intervention, assessment, referral and treatment of claimants whose recovery is impeded by alcoholism and other dependencies or other "multiple problems".

6. c) That the Workers' Compensation Board intervene with claimants whose injury history indicates a pattern of undue hazard, determine if the causative factors are occupational or personal and develop recommended corrective action as appropriate.

There is only one organization that knows the injury record of all British Columbia workers, and that is the WCB. Since the WCB is the only organization competent to know when intervention is required, it must take an active role. Failure to be pro-active will enable the problems to continue.

The purpose of intervention is to identify occupational or personal causative factors contributing to a history of multiple injuries or impeding recovery, so that corrective action may be taken to promote the long term health and well being of the worker.

Claimant Assistance Program

The Board and the injured worker establish a temporary reporting relationship during the healing process. The Task Force recommends that the Board use this temporary reporting relationship as an opportunity for intervention in cases of undue multiple claims or delayed recoveries, doing so through the means of a "Claimant Assistance Program".

The same principles, practices and confidentiality that are common to effective EAPs should be replicated in the Board's approach to intervention. The program should be "broad brush" so that problems other than alcohol or drug abuse would be addressed. The program should be advertised to encourage voluntary referrals. A graduated process of informal referrals should precede formal referrals with progression from one stage to the other based on continuing unsatisfactory performance. To ensure confidentiality the assessment and referral function should be carried out by a third party outside the control of the Board.

Need for Consultation

The Task Force believes that the probability of success of any intervention will vary almost directly with the degree of consultation that occurred between the Board and the employer and the union during the planning and implementation stages of the intervention process. It is recommended that the Board start the process through a series of pilot projects with participative and cooperative companies and unions.

Payments

The most desirable situation would occur when the intervention process, including treatment, takes place concurrently with the course of healing of the compensable injury. Such ideal situations are possible only when the length of recovery of the compensable injury exceeds the time of treatment of the personal problem. Intervention by the WCB must be regarded as an act of initiation only. Accordingly, the WCB should not be held financially responsible for any costs after the normal date of recovery. The responsibility for payments to the individual, in such cases, belongs to others. If the employer has an EAP, the existing EAP policy should apply. If the employer does not have an EAP but does have a sick leave plan, then that plan would apply. If the employer does not have a sick leave plan then the UIC plan must apply.

Maintaining WCB wage loss benefits during treatment while the injury heals makes economic sense. Two conditions are being treated for the price of one.

Industrial First Aid Attendants

The WCB has an education role to play in the matter of alcohol and drug abuse in the workplace. To ensure that at least one person on most worksites would have an understanding of the problem, It is recommended that the WCB modify the curriculum of the Industrial First Aid course to include specific training in the identification of the chemical abuser through signs of use, symptoms of alcoholism and other drug dependencies. It is further recommended that the Board's Occupational Safety Officers be instructed in that portion of the Industrial First Aid course.

7. That the recommendations of the Liquor Policy Review, June 1987, concerning beverage alcohol advertising be implemented. In addition, the Task Force recommends that the Liquor Control and Licensing Branch discourage beverage alcohol advertising that implies a connection with the worksite or depicts alcohol consumption as a rite of passage.

8. That, as recommended by other agencies, e.g. the B.C. Medical Association and the Office of the Chief Coroner, a computerized control system be developed linking all pharmacies.

Information would be available prospectively to the pharmacist and through the pharmacist to the physician, before the medication is dispensed. The prescribing history would be immediately available and would flag duplication of medications, would warn of potential interactions between medications and would pick up multiple doctoring. As a by-product physicians' prescribing practices could be monitored.

9. That consideration be given to increasing control of "over-the-counter" medications, especially codeine-containing compounds.

10. That funding be increased to the CAP (formerly ADP), to enhance existing services and to initiate additional services in identified need areas.

In order that the recommendations of the Task Force be implemented, funding to the Community Assistance Programs (formerly Alcohol and Drug Programs) must be increased from the 1986/87 level of $23.5 million.

The Task Force recommends that an additional $42 million be added to the current Alcohol and Drug Programs budget.

The Task Force recommends that the funds be raised through the sale of beverage alcohol and that they be designated specifically for Community Assistance Programs in addition to funds already committed to Alcohol and Drug Programs.

The case for raising the price on beverage alcohol is compelling. It would generate the needed funds, it would be fair - those at risk would pay, and it would promote health.

THE TASK FORCE ON ALCOHOL AND DRUG ABUSE IN THE WORKPLACE

ALCOHOL AND DRUGS IN BRITISH COLUMBIA

The Common Drugs

Alcohol: the Number One drug problem

> In order of decreasing incidence and importance as problem chemicals I see No. 1 alcohol, No. 2 marijuana and other THC compounds and No. 3 prescription and non-prescription medications.
>
> **Dr. Ray Baker, Logan Lake**

Dr. Baker's thoughts were echoed at every hearing carried out by the Task Force.

Alcohol presents by far the greatest drug problem in British Columbia. Ambivalent attitudes towards the use of alcohol are deeply entrenched in our society.

Several presenters commented that if alcohol were introduced as a new drug today it would not get past drug regulatory bodies for public consumption.

Grouping by Regulation and Legislation

Alcohol remains apart from the other common drugs with its unique legislation concerning manufacture and distribution. The manufacture of distilled beverages is controlled strictly and confined to licenced companies. Production of beer and wine is carried out by companies and by private individuals. Distribution of alcoholic beverages is controlled by a government agency and, in British Columbia, anyone from the age of 19 may purchase alcoholic beverages in a specified place at specified hours.

Pharmaceutical mood-altering drugs are available only on prescription by a licenced physician through a licenced pharmacist.

Narcotics and dangerous drugs are controlled by the Federal Bureau of Dangerous Drugs, which controls the manufacture, importation and distribution of controlled drugs and their authorization for prescribing and dispensing is required by physicians and pharmacists.

All of the products have a legitimate medical use, therefore pharmaceutical mood-altering drugs can be obtained legally from a physician and pharmacist but may be misused - deliberately or unwittingly. Licit pharmaceutical products can also be obtained from physicans or pharmacists under false pretenses (or through theft and break-ins) then end up on the black market. Mood-altering drugs are also produced illegally, e.g. cannabis (marijuana), narcotic analogues ("designer drugs") and LSD. Cocaine, heroin and THC (a cannabis extract) are manufactured and distributed legally for a very narrow medical application but are also imported or manufactured for illegal distribution.

Sedative Hypnotics

Sedative hypnotic preparations are very common in the province. Usually they are prescribed although many are available on the street market. The benzodiazepines (Valium family) are the most widely prescribed of all drugs in this class; there is much concern about the frequency, duration and inappropriateness of prescriptions. Often, insufficient precautions are given to patients about the concomitant use of alcohol. The use of sedative hypnotics - especially benzodiazepines outside of a hospital or detoxification setting - is contra-indicated in anyone with chemical dependency. In many cases they have been prescribed, with disastrous results, to people recovering from alcoholism.

The generic name for Valium is diazepam. It is available in Canada under many other trade names such as Apo-Diazepam, Diazemuls, E-Pam, Meval, Novodipam, Rival and Vivol. Although there has been a decrease in the amount of diazepam used in the province, there has been a rapid growth in preparations with shorter half-life (they are metabolized more rapidly in the body). Examples are Serax, Halcion, Ativan and Xanax. They require the same caution as any other benzodiazepine and are viewed with the same alarm by clinicians in the field of chemical dependency.

Sedative Hypnotics: General Effects

When mood altering drugs are categorized by their general effects, alcohol can be considered a sedative hypnotic drug. Also in that group are benzodiazepines, the barbiturates and several other miscellaneous sedative hypnotics such as quaaludes, chloral hydrate ether and bromides.

That list is by no means exhaustive. Benzodiazepines for example, Librium, Valium, Serax, Ativan and Halcion (these are common trade names) are widely used in medical practice, most commonly for their anti-anxiety effects. Barbiturates (e.g. Seconal and Tuinal) are far less widely used now than they were 20 years ago but are often used in combination drugs such as Fiorinal combined with aspirin and codeine.

Sedative hypnotics all have a similar net effect on the consumer. Figure 1 is a graph depicting the effect of one dose of sedative on a healthy individual.

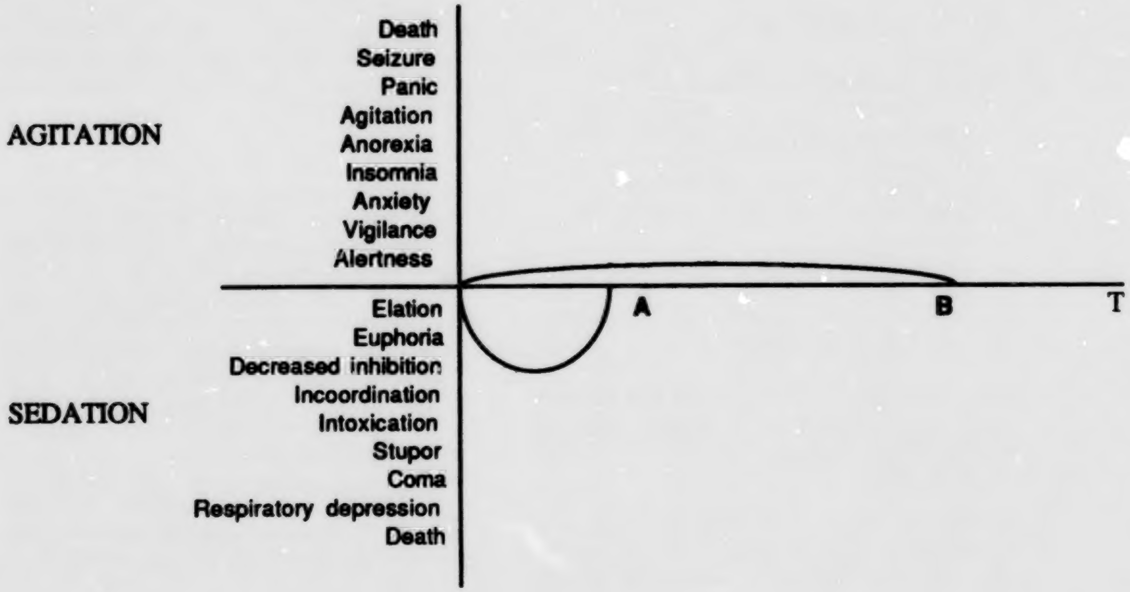


FIG 1 EFFECT OF SINGLE DOSE OF A SEDATIVE DRUG

The horizontal axis depicts the time elapsed following taking the dose at zero. The zero point on the vertical axis represents a steady state with no sedation or agitation progressing above the time axis on the agitation scale from increased alertness and vigilance-anxiety, insomnia, anorexia (unable to eat), severe agitation, panic, seizures and eventually to death at the extreme end of the scale. Moving below the time axis we have increasing sedation with initially some elation, euphoria and release of inhibitions, moving down to incoordination, loss of voluntary control, intoxication, unconsciousness, coma, respiratory depression and eventually death. The progressive stages of sedation are also known as the stages of anaesthesia in medicine.

Figure 1 demonstrates the effect of a single dose of sedative in a healthy individual. The large sedative effect ending at the letter A completely masks a rather small but longer acting agitation effect of the drug which ends at the letter B. The two effects occur simultaneously and are representative of the net effects of several complex pharmacological actions.

TABLE ONE

Combined Effects of Single Dose of Sedative Hypnotic Drugs

	A	B
	Sedative Effect	Agitation Effect
Alcohol	2 hrs.	12-36 hrs.
Barbiturate	8 hrs.	1 week
Benzodiazepine	8 hrs.	6 weeks

The combined effects of single doses of representatives from three common types of sedatives are given in Table One. For example in the case of alcohol, a single dose will produce sedation for approximately two hours with maximum sedation occurring at approximately one hour after ingestion. The concomitant agitation effect, however, is much longer lasting, i.e. 12 to 36 hours but is much smaller in amplitude than the sedation effect. It is important to note that each time a dose of sedative is taken there will be a concomitant rise in the agitation level. This is demonstrated in Figure 2.

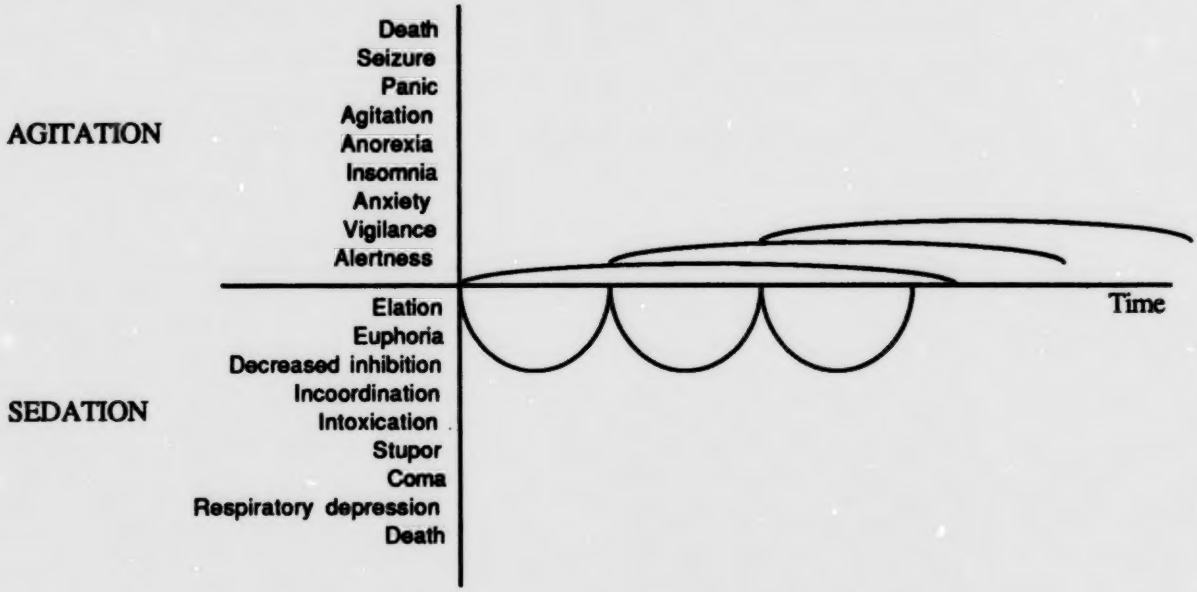


FIG 2 EFFECT OF 3 CONSECUTIVE DOSES OF A SEDATIVE DRUG

This figure represents three consecutive doses of sedative. Note that the agitation level increases with each dose of sedative. It is easy to see that chronic use of sedative will eventually produce more agitation than sedation. The graph explains the common experience of people who, having had a modest amount of alcohol on Friday evening and intending to sleep in on Saturday, find that they wake earlier than they intended and are quickly awake and alert. It also explains the hangover following heavier alcohol ingestion. It is also apparent that a large dose of sedative will relieve the agitation and malaise of a hangover temporarily. It also explains why sleeping medication is only useful in the short term. If administered for prolonged periods, the drug itself will cause insomnia and increasing anxiety. Similarly the use of anti-anxiety agents for a prolonged period merely increases anxiety and agitation.

Cannabis

Cannabis (marijuana) is seen as the second most commonly used drug in British Columbia, with nearly all those who use marijuana also using alcohol.

The combined use of those drugs poses a serious problem in our society. A phenomenon occurs when drugs are mixed; it is called synergism. The drug mixing produces an unpredictable multiplying, rather than additive, effect. The use of alcohol while taking Valium may produce four times the intoxication one would expect when considering the drugs separately.

The Le Dain Commission 15 years ago brushed off cannabis as a rather harmless and innocuous drug. Since then, available cannabis preparations have changed dramatically. The potency has increased, with most preparations at least 10 times more potent than that available in 1972.

There is little accurate information or research available on the effects of chronic use of high grade marijuana.

> New research indicates that in the case of marijuana, impairment may continue to be present 24 hours after consumption of the drug and long after the user is aware of any effect. The study reported in the November 1985 issue of the American Journal of Psychiatry was conducted on ten private pilots. After being trained on a flight simulator to the point that they could "land" successfully, each pilot was given a [marijuana cigarette]. They were then instructed to land an aircraft on the simulator's runway. As expected, at one and four hours after smoking, the pilots landed poorly. But the study discovered that even 24 hours later, the pilots had not returned to their pre-smoking performance level. One pilot actually landed his plane off the runway.
> **Alcohol and Drugs in the Workplace, the Bureau of National Affairs,Washington**

Cocaine

Cocaine is a stimulant rarely used to the exclusion of other drugs and is usually used with alcohol. It has received much attention from the media, perhaps disproportionately when considering the frequency of use of other drugs such as alcohol. Once thought to be non-addicting and relatively innocuous, cocaine is viewed now with some alarm by clinicians and, in some forms (e.g. "crack") is felt to have the highest addiction potential of all available drugs.

Narcotics

In comparison with other drug users, those who use narcotic drugs in British Columbia form a relatively small population.

The narcotic drugs are derived mainly from (or related to) opium, e.g. morphine, or are manufactured. Health care professionals, especially physicians and nurses, have the highest frequency of addiction to pharmaceutical narcotics, probably because of accessibility and familiarity with injection techniques. Heroin, available on the street market, is nearly always manufactured illegally.

Methadone is also diverted to the street market. This long-acting narcotic is used to help heroin addicts to withdraw from their use and stabilize their lifestyle.

Over-the-Counter Drugs

Over-the-counter (non-prescription) drugs, of which the most common are codeine-containing pain relievers, are widely used and misused. Codeine is a narcotic but, combined with acetylsalicylic acid (aspirin) or with acetominophen, it can be purchased freely in a pharmacy. Great concern was expressed about this group of drugs and the severe addictions being maintained through over-the-counter purchases. In the United States these preparations are available only on prescription, creating a brisk market "over the line".

Combination Preparations

Fiorinal Cl/2, for pain relief and sedation, contains aspirin, caffeine, codeine and a barbiturate known as butalbital. It is diverted to the street market for brisk illegal trading, moreso in British Columbia than in any other province. In spite of the fact that most official bodies and drug review committees warn physicians repeatedly that the drug is of very questionable value, it continues to be prescribed and distributed on the street market.

Alcohol and its Effect on the "Normal" Population

The mood state in sober social drinkers can have a great effect on decision making. With up to 80 percent of the population using alcohol - a drug that can increase anger, depression and mental confusion even in the sober state - the implications are profound. Alcohol has been shown to be an important factor in the development of female breast carcinoma. As our knowledge expands we understand that society's attitude towards this drug must change dramatically if we are to prevent the present havoc and destruction from continuing.

Alcoholism and Other Addictive Disorders

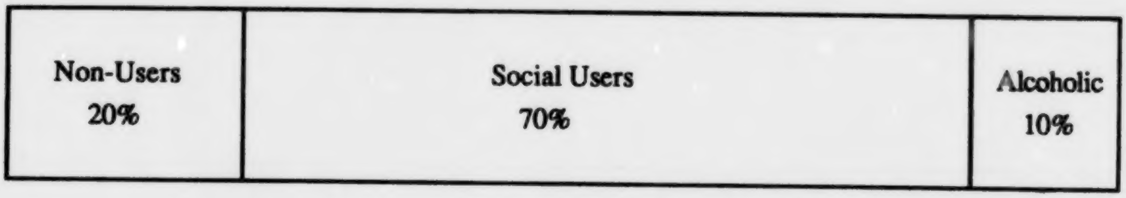
Terminology

Addictions... dependencies... abuse... misuse... psychological dependence...physical dependence. Those terms, even when used quite specifically, may be used in a different sense by different clinicians.

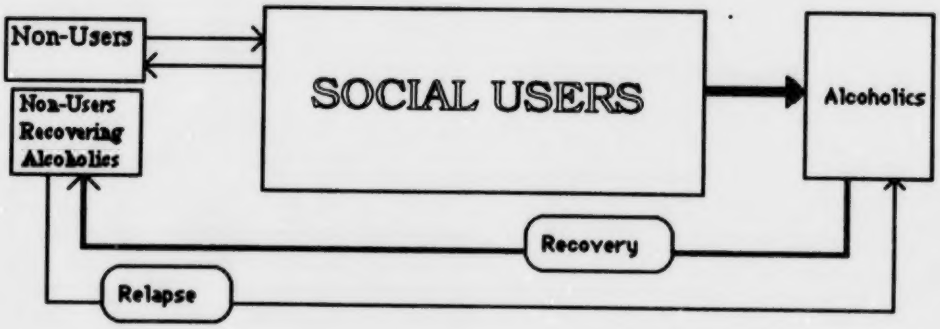
The Addiction Process

Social users represent the current population at risk for development of alcoholism.

This bar chart shows the adult population represented in the Task Force statistics.



However, it would be a mistake to regard this as a steady state; there is constant movement among the groups.



Alcoholism is a chronic illness that affects people physically, mentally, emotionally and spiritually, without regard for social class, economic status, race or gender.

All alcoholics once belonged to the social users group - albeit briefly for some. Alcoholics, once established as such, do not return to the social user group; they are in need of intervention and treatment to help them to move into the non-user group. Non-users may need encouragement and support and they deserve positive reinforcement.

People are moving from the social user group to the alcoholic group at an earlier age and there is an increasing tendency to use more than one kind of drug. In the past 20 years, the average age at which people first "drink" has dropped from 18 to 14 years and they reach the "at risk" group at an earlier age.

Prevalence

Alcoholism is one of the most common illnesses in British Columbia. Ten percent of the adult population suffers from alcoholism.

Although the word "alcoholic" conjures up the skid road derelict, no more than 5 percent of alcoholics are found on skid road. Most hold jobs, and they can be found in all companies, occupations and industries and at all levels, from mine workers to top management and in all

> **locations, from the isolated work camps of the North to the construction sites of the lower mainland.**
> **B.C. Construction Industry Rehabilitation Plan**

Disease or Learned Behaviour?

There are two basic schools of thought concerning the causes of alcoholism. Most professional health care groups and health care payment agencies in North America see alcoholism as a disease or illness. The other major school of thought regards it as a learned behaviour. Among the presentations made to the Task Force, a great majority supported the disease concept.

The "behavioural" school criticizes the "disease" supporters, alleging that the patient can avoid personal responsibility by saying, "I am ill, therefore I can't help myself." Conversely, the "disease" advocates say that the "behavioural" school can help the patient avoid responsibility because of the outside factors that "caused" the alcoholism, e.g. parents, job, drinking friends. Alcoholism is a complex disorder, probably embracing both of those theories.

"The Great Pretender"

Some physicians feel that alcoholism is a contender for the title "the great pretender". It masquerades as many other illnesses, resulting in vast numbers of health dollars being spent inappropriately and ineffectively. Left untreated, alcoholism will ultimately affect one or more of the body's systems, often with fatal results.

Of topical interest is alcohol's effect on the immune system. Cocaine and amyl nitrate interfere directly with the immune system. We know also that alcohol lowers inhibitions. Those two factors put people at great risk of contracting the AIDS virus; in that event, if chemical dependency continues, progression to the full-blown disease is much more likely. That conclusion is drawn from recent evidence that AIDS virus carriers treated for chemical dependency are much less likely to develop the syndrome.

(Recommended for further information on the effects of alcohol on the body: the section on medical complications in "Understanding Alcohol", Kinney and Leaton, Mosby, 1982.)

Emotional and Spiritual Illness

People use alcohol for the effect it has on the central nervous system.

> **Alcohol is a drug that has a profound effect on the brain cells.** This simple statement should suffice to raise a strong suspicion, when a person is not functioning optimally, that alcohol may be the cause. The brain has more than four and one half billion cells, all interconnected in a complexity that would make the most complicated sophisticated computer seem like a Tinkertoy. Intoxicating this exquisitely sensitive complex brain with alcohol or other drugs is like hitting it with a heavy sledge hammer. In fact, that is exactly what alcohol toxicity is: a chemical sledge hammer. Obviously, a sensitive instrument struck by a sledge hammer is going to function improperly, regardless of how hard the operator of the instrument tries to make it work well.
> **Abraham J. Twerski, M.D., Caution, Kindness Can Be Dangerous To The Alcoholic, Prentice Hall, 1981.**

It is that "sledge hammer" effect that shows up as impairment of function in the workplace. Loss of productivity, inappropriate behaviour and dangerous actions affect not only the worker but also co-workers, the employer and the worker's family. Each in turn will affect the community at large. Because of the complex nature of those interactions the total cost to the community is inestimable.

Reaction to any mood-altering drug can mimic psychiatric illness such as schizophrenia, chronic depression, Alzheimer's disease and sociopathic disorders. In fact, it is impossible to diagnose those disorders until thorough detoxification is achieved where necessary.

Alcoholism is a disease of the emotions. It can make the sufferer feel isolated and lonely, angry and hostile, guilty and worthless, depressed and anxious. In the short term alcohol and other drugs mask emotional difficulties effectively. In the long term they magnify all of those emotional states and the ability to cope spirals downwards. Alcoholics do not use to get "high", they use to feel normal.

Alcoholism is a chronic illness that affects people physically, mentally, emotionally and spiritually. The illness is there whether or not the drug is currently in use or even present in the bloodstream. Everyone, irrespective of religious background, needs a philosophy that defines their position in creation as a whole - a concept of purpose or direction is necessary for full development. For the alcoholic suffering emotionally, spiritual well being is impossible.

Intoxication is only one aspect of alcoholism: to understand the disease, knowledge of all its manifestations is required.

The Hangover

Even when the drug is no longer detectable in the bloodstream, its effects remain. The "hangover" is a prime example of that condition.

Most people who use alcohol know the reality of impairment caused by a hangover. If never experienced personally, the effects of the hangover undoubtedly have been observed in others. It is easy to imagine the difficulties of performing a rigorous, complex task under the effects of a hangover.

Many presenters discussed the severe impairment in coordination, judgment and emotional state that hangovers cause on the worksite.

Family Illness

One of the earliest problem areas for the alcoholic is the family relationship. The alcoholic family knows nothing of stability, consistency or behavioural appropriateness. Relationships become distorted and true closeness becomes an impossibility.

When denial and enablement plus the emotional and spiritual illness of alcoholism are blended, the result is usually disaster. Often, the family of the alcoholic is in more need than the alcoholic. Furthermore, if the cycle is not broken, the inappropriate relationships are passed on from generation to generation. Daughters of alcoholic fathers tend to marry alcoholic men. Similarly, women who divorce an alcoholic and remarry tend to marry another alcoholic. The children of alcoholics, besides being genetically more prone to develop alcoholism, often have a poor chance of developing successful marital relationships later.

Family members of alcoholics who form inappropriate dependent relationships are called "co-dependents". The alcoholic worker can be impaired in the workplace whether or not they are currently using alcohol or other drugs. Similarly that "co-dependent" may be a hazard in the workplace because of emotional or mental impairment. Intervention, assessment, referral and treatment are just as essential for the co-dependent worker as the alcoholic worker.

Many clinicians in the field of chemical dependency insist that treatment of the alcoholic alone without treating their family is unlikely to be successful.

Denial and Enablement

Blaming job stress for the drinking is a self-enabling form of denial. It is an attractive illusion to those seeking justification for their behaviour. There is an element of truth; stressful worksites do exist, some more so than others.

> ...Just as the idea of an abuse-prone individual is a valid one, so is the idea of an abuse-producing environment a valid concept.
>
> Several factors in the workplace may influence the likelihood of individuals becoming more susceptible to substance abuse. The ways in which work is organized, for example, or the meaning the work has for the individual worker can contribute to worker alienation. The opportunity the worker has to gain self esteem and achieve life goals through work activities, the ways in which the worker is treated by co-workers, supervisors and bosses, or the ways in which conflicts with authorities are resolved at work can all contribute to the tensions and frustrations leading to substance abuse. The climate of care and concern which exists at work (which is demonstrated not only through services available, but through attitudes toward workers' contributions) can also contribute to the likelihood of alcohol and drug abuse.
> **Dr. R. Carr, Victoria**

To a certain degree, reducing conflict, frustration and other sources of dissatisfaction will remove factors that contribute to the development of an individual's substance abuse. But the illness is not always explained by stresses in the workplace. Substance abuse is found in all walks of life - in and out of the worksite environment and among people with no employment responsibilities at all.

> Under no circumstances should attention to environmental conditions as potential explanations of drug and alcohol abuse be confused with an individual person using the existence of these conditions as an excuse for the problem behaviours which come about as a result of contact with these conditions. Rather than

> assigning blame, the need is to identify the degree of risk associated with external factors in producing rather than reducing problems and to create alternatives which can change or modify those conditions.
> **Dr. R. Carr, Victoria**

Substance abuse must not be seen as the inevitable result of occupational stress but as an inappropriate response to stress, whatever its source.

Family members and friends of individuals suffering from alcoholism or drug dependency also engage in denial. We were told that many professionals have an aversion to "labelling". Unfortunately, avoiding the use of the diagnostic label assists in the process of denial. A presenter felt that the whole problem was one of cover-up by workers, union, senior management and physicians, that these people were afraid of labelling others as alcoholics or drug addicts because of the implications of the label.

> Even when problem drinking is recognized, many of us have a tendency to look the other way and to say, "There, but for the grace of God, go I", in the mistaken belief that we are being kind to the drinker. As physicians we have learned that to ignore a problem drinker's disease is neither kind nor responsible.
> **B.C. Medical Associatian**

> Cover-up and denial is as prevalent in the workplace as it is in the family situation. Denial and cover-up is a fact of life in the addiction field.
> **B. C. Hydro**

A prime example of societal denial is in our attitudes towards impaired drivers as reflected in the actions of the courts.

> [Yet] we know that there are problem drinkers in B.C. with as many as nine previous convictions for impaired driving who still hold a licence to drive in this province. One such problem driver is still drinking and still driving, while awaiting trial for allegedly killing several people on the highway. The justice system, and hotel owners and our society must all bear a share of the responsibility for such tragedies.
> **B.C. Medical Association**

Many presenters felt that if "the boss" has an active alcohol problem it is unlikely that attempts to intervene for employees lower on the scale will be successful.

> Alcohol and drug abuse in the workplace is not limited to any particular level within an organization and is today a problem at every level, from the boardroom to the shop floor. The denial or cover-up of a problem existing may only increase the higher in an organization the problem goes.
> **Bob Cunningham, Crows Nest Resources**

By denying that a problem exists, we enable the problem to continue. Denial in all its forms, whether by society at large, by the employer, co-workers, union, physician or family members, results in the alcoholic being "enabled" to continue in their illness.

> Shop stewards and supervisors, managerial people as well as line workers, often will enable the alcoholic to continue drinking by covering up his problems. They may be old friends and drinking buddies, and have worked together for many years. They believe they are helping him by not blowing the whistle on him.
>
> In fact, they are helping his illness to progress unchecked.
>
> The alcoholic can be helped. Everyone connected with him, management, unions, co-workers, family and friends must stop covering up and enabling his alcoholism to progress. *They all have a responsibility to help him recover from his illness.*
> **B. C. Construction Industry Rehabilitation Plan**

The Task Force repeatedly heard submissions critical of the role of the physician in the chemical dependency field. Many felt that the physician was often an enabler.

> The physician can indirectly enable a patient by not carefully asking about his or her use of alcohol and other chemicals.
>
> A more direct enabling behaviour is the failure of the physician to diagnose

> alcoholism even when its signs and symptoms are obvious.
>
> Direct enabling [occurs] with the prescribing of narcotics, sedatives, stimulants, or minor tranquilizers, when the physician knows that the patient is chemically dependent or suspects, or should suspect, that these chemicals are not indicated.
> **The Physician as Enabler of the Chemically Dependent Patient, Richard O. Anderson, M.D. Post Graduate Medicine, June 1986**

One sad example of denial and enabling is reflected in the recent federal report on the battering of women. Although chemical dependency is well known as the most common factor in family violence, both in the battered person and in the perpetrator, most organizations dealing with battered women and family violence deny that this is a factor. They feel that admission of alcoholism as a factor will give the perpetrator an excuse to continue their behaviour, saying, "I can't help it, I'm an alcoholic". It is virtually impossible to eliminate violent behaviour in an offender who continues a pattern of chemical dependency.

Up to 80 percent of the province's adult population use alcohol. Changes in attitudes will be brought about only by a massive education movement.

The Treatable Illness

> Alcoholism does respond to treatment. Of all ills, it has, when properly approached, the highest rate of potential recovery.
> **Dr. J.G. Strachan**

Chemical dependency is most amenable to treatment; as many as eight out of 10 alcoholics can be helped. Few chronic, potentially fatal relapsing illnesses have that chance of recovery.

The most dramatic example is the story of the community of Alkalai Lake, British Columbia, which moved from the despair of a 98 percent alcoholism rate in 1972 to a 90 percent recovery rate in 1985. The recovery of one person in 1972 was followed by the community of about 500 people becoming deeply involved in mental, emotional and spiritual recovery.

Because chemical dependency is so insidious and wreaks such havoc, yet is so amenable to treatment, we must motivate ourselves to confront the problem and learn to deal with it. We must have the courage and strength to share the task of self education and to intervene and confront where appropriate. The alternative is to go on denying and enabling, thus allowing the costs in human suffering and inestimable dollars to continue.

The Million Dollar Illness

In their presentation to the Task Force, the St. Patrick's House Society of Prince George called it "the million dollar illness". Once alcoholism has progressed to the point of interfering with employment, the alcoholic imposes an increasing cost on society. When that occurs early in life and the alcoholic lives long enough, the cost to the community can be as high as a million dollars, exclusive of property damage.

St. Patrick's House defined four main categories of expense:

Income Supplements
- the employment loss cycle
- unemployment insurance benefits
- welfare assistance

Hospital and Medical
- health-related costs mount
- visits to doctors - for relief and for prescriptions to satisfy a poly-drug habit
- injury while impaired
- victim of violence
- frequent use of emergency service
- repeated use of detoxification facilities
- medical complications lead to hospitalization

Treatment
- relapses require serial treatment
- outpatient counselling
- residential treatment
- halfway houses

Legal and Justice
- alcoholism leads to trouble with the law
- public drunkenness can result in overnight stay in jail
- impoverishment may prompt criminal behaviour
- legal aid
- jail term

St. Patrick's House conducted a limited study on the cost to the community of continuing active alcoholism. Six of their clients were chosen at random and interviewed in detail on their drinking history. All participants were male and all started drinking in their teens. They came from low, middle and upper middle income classes. At the time of the interview, all participants had stopped drinking and were in recovery. The history was taken from memory and was not independently verified. It was stated that some of the admissions may have been a low estimate. These are the results of the study:

ST. PATRICK'S HOUSE - SURVEY JULY 1986

CLIENT'S DRINKING PERIOD	A 19-31	B 16-24	C 17-34	D 18-39	E 19-36	F 19-36
Hospital & Medical						
Visits to Doctors	50	50	5	100	5	2
Emergency Use	22	20	3	6	35	2
Detox - (Days)	290	36	3	265	175	-
Hospital Stay (Days)	-	49	7	100	10	-
Estimated Costs	**$115,070**	**$35,925**	**$4,280**	**$143,185**	**$75,175**	**$260**
Income Supplement						
UIC (Months)	-	5	12	-	-	36
Welfare (Months)	95	60	24	144	18	24
Estimated Costs	**$38,000**	**$30,000**	**$19,200**	**$57,600**	**$7,200**	**$52,800**
Treatment						
Residential (Days)	56	28	-	180	300	2
Halfway House (Days)	1,345	200	210	120	426	90
Outpatient (Times)	177	200	28	100	20	15
Estimated Costs	**$69,695**	**$22,000**	**$9,940**	**$30,100**	**$51,140**	**$4,645**
Legal and Justice						
Court Appearances	4	30	20	10	35	40
Overnight Jail (Times)	50	75	1	12	5	40
Jail served (Days)	-	400	3,656	3,204	3,656	730
Estimated Costs	**$8,750**	**$77,125**	**$420,555**	**$377,340**	**$421,015**	**$118,550**
Total Est. Costs	**$231,515**	**$165,050**	**$453,975**	**$608,225**	**$554,530**	**$176,255**
Avg Cost/Year	**$19,293**	**$20,631**	**$26,704**	**$28,963**	**$32,619**	**$10,368**

The cost assumptions used by St. Patrick's House Society were:

Doctor's visits - $20/visit
Emergency Service - $110/occurrence, based on 2 hrs/visit at $55/hr, to include lab work, X-rays & medical staff
Detoxification and Hospital Stays $385/day
UIC Benefits - $800& $1200/month
Welfare - $400/month
Treatment Centres - $110/day
Transition House - $40/day
Outpatient Counselling - $55/hour, one hour per visit
Court Appearances - $750/occurrence
Jail Time - $115/day

The Task Force accepts the cost assumptions as being reasonable for the purpose of illustrating that some alcoholics can be a heavy financial burden on the community. It doesn't matter if the cost estimates are marginally in error, the general thrust of the message is valid. The chart vividly portrays the bleakness of lives of chronic alcoholic disorder. As long as the drinking continues there will be mounting financial consequences. It is apparent that rehabilitation of the alcoholic is the only way to limit the costs to the community. It is obviously cost effective to expend funds on treatment in order to save money in the long term.

Extent of the Problem

The effects of alcohol and other drugs in the workplace - and in society in general - are extremely difficult to quantify on a scientific statistical basis.

> In view of the difficulty in determining exactly how many individuals in society are using drugs, [it is impossible to estimate] how many individuals in the workplace are using, misusing or abusing drugs and the effect this is having on health and safety.
> **Marg Fritz, Phoenix Centre**

> In fact, there is a great lack of information and statistics available on drug abuse in Canada. There are no causal studies available on its effect in the labour force, its economic cost to industry or how predominant the problem actually is.
> **Canadian Construction Association**

Conclusive evidence about the use of alcohol or other drugs depends on laboratory analysis of bodily fluids. Collecting those fluids imposes ethical complexities on the task of compiling the necessary statistics.

No legal mechanism exists for obtaining toxicology samples in non-fatal worker injuries, so no data accurately reflect the role played by alcohol or other drugs.

> Informed observers blame the embryonic stage of research in this field largely on the difficulty researchers have in gaining access to study sites.
> **Journal of Occupational Medicine, Vol. 27 No. 10 October, 1985**

The under-reporting and under-diagnosis of alcohol and other drug-related disorders almost certainly is a reflection of society's denial of the problem. A dramatic demonstration of that appeared in a recent study at Victoria's Royal Jubilee Hospital. A retrospective study of all its cases with a diagnosis of pancreatitis revealed that the disease, with a normal 80 percent association with alcoholism, had alcoholism mentioned *in only one case in the three-year study*. The diagnostic term was used incidentally and even that case was not referred for treatment of the alcoholism.

> **It has been authoritatively estimated that [the costs of alcohol] exceed two billion dollars per annum in British Columbia, or $5.00 for every dollar collected in liquor taxes.**

> **It is no coincidence that British Columbia has the highest per capita consumption of alcohol as well as the highest prevalence of traffic accidents, suicide and cirrhosis of the liver in Canada.**
>
> **British Columbia Medical Association**

> [Of] 300 people [interviewed on] a random basis in B.C., [it was] found that 10 percent of this group used cocaine, a major increase from previous information which suggested four percent of the population were using cocaine.
> **Kaiser Substance Abuse Foundation**

> Less than five percent of alcoholics live on Skid Row. Between 60 and 70 percent of our clientele are employed, yet only six to eight percent are referred to us from an official Employee Assistance Program.
>
> Federal government statistics tell us that between 1967 and 1980 the number of alcoholics in Canada went up by 100 percent, 10 percent of workers are either alcoholics or heavy problem drinkers and cost companies 25 percent more than their salaries through absenteeism, sick pay and accidents. Only five years ago we had no one coming to us with a cocaine problem, now 10 percent of our clients are addicted to cocaine. What about our future employees who are now in high school?
> **Alternatives, North Vancouver Alcohol and Drug Treatment Service.**

This cycle of entry into the system with attendant escalating cost will end only when the chemical dependency is treated as a primary disorder.

The changing patterns of drug use today will have a major effect on health care needs in future. The high incidence of multiple drug disorders in young patients will result in increased demands on the existing system of care.

> A study at the Victoria General Hospital in 1985 demonstrated that 40 percent of

> male patients aged 19 and over had demonstrable problems with their use of alcohol. This compares with an estimated six to ten percent for the total adult population. Despite this, we do not screen our hospital patients effectively for alcohol abuse and many do not receive optimal rehabilitative care.
> **Alan G. Clews, M.B., Chairman, Alcohol Dependency Committee; B.C. Medical Association.**

> In 1986 out of 11,901 arrests for serious crime, 4,323 admitted drug use. This represents 36.3 percent. In the first quarter of 1987 this had risen to 39.2 percent.
> **Vancouver Police Dept.**

Between *70 and 80 percent* of males serving time in our penal system were under the influence of alcohol at the time of the crime or alcohol was a significant contributing factor. The cost impact on our judiciary system is stunning.

> Seventeen percent of the workforce consumes alcohol in amounts that put them in danger of developing a dependency. Seven to 12 percent of the Canadian workforce abuse alcohol and three to five percent are affected by other legal and or illegal drugs.
> **Martin Shain, Addiction Research Foundation of Ontario**

Fifty percent of clients treated at a Vancouver out-patient clinic in 1986 were found to have used cocaine.

Where testing was done, according to the British Columbia Workers' Compensation Board, alcohol was present in the blood of 15 percent of victims of fatal injuries from 1981 to 1985. Blood alcohol levels in excess of 80 milligrams of alcohol in 100 millilitres of blood (the legal level of impairment) was found in almost nine percent of fatalities.

> A student survey of high schools through the province of B.C. showed that 30 percent have an alcohol problem, 15 percent marijuana problem,15 percent cocaine.
> **Will Mundy, Prince George**

> The government must undertake some in-depth research studies to determine which types of treatment are the most effective.
> **B.C. Construction Industry Rehabilitation Plan**

> Alcoholism should be a reportable disease.
> **Commander Ian Buckingham, Canadian Forces Base Victoria - Alcoholism Rehabilitation Centre.**

It was suggested several times that the field of chemical dependency should have its own lobby group, similar to the Cancer and Heart Funds, and the societies for the mentally handicapped, who lobby for funding and recognition within the community. One of the obstructions to the formation of such a group has probably been concern about anonymity for individuals in recovery. It was recommended that such a lobby group should be composed of up to 50 percent non-chemically-dependent recovering people. Its function would be to ensure that the services needed are in place, as well as advocating for those who have addictions.

There is also a need for coordinated, standardized data gathered by governmental and private agencies on alcohol and drug use, the societal and personal effects, the disposition of those affected and the outcome of such disposition.

Productivity

Impairment in the workplace, from whatever cause, will decrease productivity. Specifically, workers with chemical dependencies will have an impact through:

1) Absenteeism
   - absentee rates from three to eight times greater than for non-addicted personnel;
   - increased costs on benefit plans and overtime;
   - lower production with under-manned crews;
   - inefficiency through less-skilled substitute workers;
   - disruptions of routine;
   - morale problems for others generated by the absences.

2) Accident Costs
   - more compensation claims (some estimates indicate up to five times the average)
   - estimated: for every $1.00 spent on wage-loss and medical aid for injured workers, from $5 to $20 goes to equipment damage and down time;
   - impaired cause non-injury accidents that result in damage and production loss.

3) Industrial Relations Costs
-conflicts resulting from poor attendance and performance, unsafe work procedures;
-those conflicts cost thousands through demands on personnel staff, fees for arbitrators and legal counsel.

4) Other Impacts
-disturbs straightforward communication with supervisors, fellow workers and business associates.

Population Sub-groups

There are groups within society whose needs are not being met under the present system of care.

Children

> Approximately two-thirds of sexual abuse of children occurs in homes where there is problem drinking and alcohol plays a similar role in other forms of physical abuse of children.
> **B.C. Medical Association**

The median age for onset of drinking is 14. A sizable number of children under the age of 10 will have used alcohol and a small proportion of those will be addicted and require intervention. Few agencies seem to be willing to deal with the issue and the condition may be dismissed or denied.

Assessment of the child and the family by someone competent appears to be sporadic. One presenter felt that the issue of taking drugs "because it is fun" must be addressed. Children mimic adults and their peers and infer from the media that the use of alcohol and other drugs is pleasurable.

Youth

Adolescents themselves perceive alcohol and other drugs as the most serious problem facing them.

The use of mood-altering chemicals during adolescence, the period of greatest emotional growth, is hazardous in the extreme. The earlier they are used the greater the chance of development of addiction. The province has far too few resources devoted to the needs of the chemically dependent adolescent. The lack of assessment, referral and treatment services for children and youth was cited at least once in every hearing.

Today's impaired adolescent is tomorrow's impaired worker.

> ...Those clients who develop serious substance abuse problems during adolescence are unable to persevere in our educational system and indeed cease to develop an emotional maturity...and social skills, leaving them woefully unprepared to gain entry and compete in a....competitive labour market.
> **Cranbrook Probation and Family Court Counselling Staff**

Seniors

Several factors contribute to the increased risk for seniors to develop chemical dependency (and make intervention more difficult):

- the emotional transition state of retirement;
- increased likelihood of bereavement;
- the frustration of decreased mobility;
- helplessness when unable to care for self or spouse;
- the giving up of the home to move to a residential facility.

Seniors are more likely to need and receive prescribed medication, with sleeping medications and other mood-altering drugs the most common. Tolerance to drugs decreases with advancing age. Like the general population, most seniors use alcohol. The synergistic effect of small amounts of alcohol being combined with small doses of sedatives can cause impairment and decreased quality of life.

Seniors are often isolated physically and emotionally from appropriate intervention sources.

Defeatism abounds in care-givers when there is an inability to understand the impact mood-altering drugs produces in seniors and because of the common attitude that the elderly "have earned" their consumption of alcohol, which is often seen as the "reward". An evening "happy hour" at senior care facilities usually is intended as a kindness but often has the effect of raising the level of care requirements. A facility in Prince Edward Island demonstrated the dramatic effect of radically cutting the amount of mood-altering drugs given to residents; several left to set up on their own in the community and the level of activity of other residents improved significantly.

Children of Alcoholics

Children of alcoholics are at high risk of development of chemical dependency. They are also at great risk of experiencing severe personal difficulties, especially in the area of interpersonal relationships.

> Children who grow up in a home where one or both parents abuse alcohol or other drugs generally experience significant adjustment difficulties. These problems often do not surface until adulthood at which time they can have a serious detrimental effect on the individual's functioning. Such problems are prevalent enough that the treatment needs of "adult children of alcoholics" has, in recent years, become a major focus for alcohol and drug counsellors and self help groups. The impaired functioning of the large number of people in this category must surely have a substantial impact in the workplace. Furthermore, it is well documented that children who have one or more alcoholic parents have at least a four times greater likelihood of developing a dependency problem themselves.
> **Cranbrook Relocation and Family**
> **Counselling Service**

Besides the legal and correction systems the school system particularly will observe the behaviour and the problems of children of alcoholics.

> School counsellors and teachers have become increasingly aware of the children of alcoholics in the school setting. While most of these students are not problems, in fact they are often over-achievers, we are aware that they are missing out on many of the joys and pleasures of being children and that they are at risk of being alcohol abusers themselves or marrying alcohol abusers. An increasing number of secondary age students are coming forward to discuss their problem, but there is often no solution for them as their parents are often not willing to seek help. Many of these students are afraid that the parent will discover that he or she has sought help and that there will be reprisals. Most often at that age the abuse is psychological rather than physical so there is reluctance, rightly so, on the part of the Ministry of Social Services and Housing to become involved. It seems to us that the missing link in this situation is the detection of alcohol problems in the workplace and a non-punitive process for helping these parents and other people with drinking problems to gain control over their problem. We could then feel that there was hope for the students to have a happier home life, to grow up slowly, and to not be at risk for repeating the pattern.
> **Courtenay District Counsellors**
> **Association**

One presenter stated that many children of alcoholics enter the helping professions and that these professions, especially nursing and medicine, must be made aware of the potential problem surrounding individuals who come from a chemically dependent family background.

One outpatient clinic, Alternatives in North Vancouver, told the Task Force that one-half of their clients were children of alcoholics.

Unless appropriate help is being given to their family, children of alcoholics will experience personal difficulties when they grow up. They experience marital break-up at a much higher rate than the general population. Statistics show that daughters of alcoholics tend to marry alcoholics. Women who divorce alcoholics tend to marry another alcoholic.

Considering that the rate of alcoholism among children of alcoholics is up to four times higher than in the general population, adult children of alcoholics are likely to bring personal problems to the work environment. Clinicians in chemical dependency have become increasingly focused on children of alcoholics and feel that they are an obviously important target for prevention efforts. They can only be helped if skilled assessment and referral is available. However, many outpatient clinics are unable to deal with the extra client load. The self-help group Adult Children of Alcoholics is very effective and has been growing rapidly in the province.

The Working Poor

There are barriers to treatment for those with marginal incomes. Conversely, the unemployed have the time to attend treatment facilities and have a *per diem* cost paid by Social Services and Housing. High earners can afford the time and cost of treatment.

> The cost to the client of residential treatment centres is running just under $500. For the working poor who are not eligible for any sort of assistance this cost, while incredibly reasonable considering the overall cost, is still prohibitive.
> **Jocelyn Wood, Cariboo Friendship Centre, Williams Lake**

The *per diem* cost levied on the client by residential treatment centres was criticized and seen as the main reason why many eastern British Columbians go to Alberta for treatment at a cost of $20.

Reducing or eliminating the charges would remove a major barrier to treatment; of further help would be outpatient services offered outside working hours.

The White Collar Worker

Most Employee Assistance Programs are the result of cooperation between the union and the company. Too often the white collar worker is left out of the process.

In discussing the question, "What if the boss is an alcoholic?", Task Force presenters felt that the situation is especially difficult in small firms with no EAP.

> Some of the occupations that fall into the hard-to-reach category are: physicians, attorneys, accountants and other professionals; university professors; itinerant sales personnel; delivery persons; drivers of all sorts, including long distance truckers; managers; franchisees of large companies....and outpost employees on oil rigs or telephone lines."
> **Alcohol and Drugs in the Workplace, a BNA Special Report, Bureau of National Affairs, Washington, DC.**

Women

While addiction to alcohol and other drugs is a process with recognizable characteristics common to all those affected, there are issues specific to women's life experience that have important implications for both the diagnosis and treatment of substance abuse in women. The issues that women bring to treatment are not specific to chemical dependency but to being a woman and include not only physical differences but also differences in social training and cultural expectations.

Because assessment and treatment services were often developed by men for male clients, these services may be more suited to deal with issues characteristic of male experience, rather than being gender neutral, as is often assumed. Society as a whole seems to assume that an alcoholic is a man and that a woman who abuses alcohol or other drugs is somehow more deviant.

Extent of Alcohol and Drug Abuse Among Women

A number of factors make it difficult to assess accurately the prevalence of substance abuse among women. Women usually constitute a minority in the population served by alcohol and drug treatment programs: male/female gender ratios in U.S. programs range from 2:1 to as high as 10:1. However, this may well represent the failure of these programs to attract women clients rather than the proportion of women who need help. EAPs have been especially criticized on the basis that women are underrepresented compared to the number of female workers, especially in referrals for alcohol treatment. It has been frequently suggested that the strong social condemnation of women who have alcohol and drug problems, combined with paternalistic protectiveness toward women, results in failure to identify and treat women for chemical abuse. Until basic attitudes change, the number of "hidden alcoholics" among women will remain unknown.

What is known is that drinking patterns among women have changed, so that young women are now as likely to drink as young men, although many more older women than men abstain. In spite of large increases in the prevalence of drinking among women, especially those who work outside the home, women are still more likely to abstain and to drink less than men.

Research on quantity of drinking often is confounded by failure to adjust for women's lower average body weight and the additional factor of proportion of body fat to water, so that the damage to women is underestimated.

It is also known that women in Canada receive twice as many prescriptions for tranquilizers as men. Even if women are less likely to abuse alcohol, when abuse of prescription medication such as tranquilizers and sleeping pills is added to abuse of alcohol, the number of women with problems may well be equal to men.

Issues for Women

Women who abuse alcohol and other drugs are characterized by certain issues specific to women which have implications for effective diagnosis and treatment.

Stigma:

Because substance abuse is in conflict with the idealized wife and mother roles, women will deny their problems with alcohol and drugs and do whatever is necessary to avoid being labelled.

Telescoping:

Women often report fewer years between beginning drinking and seeking treatment than men, suggesting the importance of early intervention for women, as chemical dependency may progress more rapidly.

Low Self-esteem:

Women alcoholics report even lower self esteem than male alcoholics, which may be a barrier to recovery and lead to premature dropouts. Lack of assertiveness and dependence on others are related issues.

Poverty:

Although women of all socio-economic levels are affected by chemical dependency, women are more likely than men to be unemployed, poorly trained, employed at low wages or to be single parents. Lack of money to pay fees or child care costs associated with treatment may be a barrier.

Cross Addiction:

Many women are cross addicted to alcohol and other psychoactive drugs, which complicates withdrawal and treatment. Cross addiction may result from physicians prescribing psychoactive drugs to women who present with emotional problems but are actually alcoholic.

Sexual Abuse and Violence:

The Aurora House Women's Treatment Centre survey of 100 clients treated between January 1985 and October 1986 found:

Dual Addictions	93%
Alcohol Only	7%
Eating Disorders	30%
Experienced Violence in Relationships	75%
Victims of Adult Rape	52%
Experienced Physical Abuse as Child	67%
Experienced Sexual Abuse as Child	83%
One or both Parents were Addicted	86%
Other Family members addicted	78%

Abuse of Own Children or Children in Care	
Emotional	35%
Physical	26%
Sexual	4%

Known Abuse to Women's own Children by Others	
Emotional	10%
Physical	6%
Sexual	12%

These problems resulted in long-term damage to self image. Relationship ability may also be a serious barrier to recovery for these women. Some women will be unwilling or unable to deal with these issues with male counsellors or in mixed groups.

Child Care:

Because women bear the brunt of child care and place a very high priority on family responsibilities, lack of child care can be an enormous barrier to treatment. Self-esteem may be dependent on adequate care and contact with children.

Fetal Alcohol Syndrome:

An additional risk that women face is the possibility of damage to unborn children from the use of alcohol or other drugs. They will also assume the burden of care of children who are damaged.

Problems in Identification and Intervention

Alcohol and drug abusing women, like men, do seek help but not for alcoholism and drug dependency. Instead, a wide range of problems will be presented such as depression, anxiety, stomach trouble and injuries from alcohol related accidents or physical abuse, and the underlying addiction problem may not be identified. Women are particularly likely to present with depression and anxiety and to be referred for mental health treatment. At best this will be ineffective, at worst it will result in prescriptions of psychoactive drugs with the possibility of dangerous synergistic effects, as well as cross addiction.

The social stigma of alcohol and drug abuse for women also results in reluctance to seek help from or accept referrals to agencies which are identified as alcohol and drug treatment. That implies that "broad brush" EAPs will likely attract more women than those labelled as alcoholism programs but it does not solve the problem of identifying an addiction problem in a female employee. Supervisors are often less willing to confront a woman or to take disciplinary action because of fear of an emotional reaction or because of the stigma previously discussed.

Alternatively, the nature of the work that many women perform makes them anonymous or invisible to their supervisors, and problems with alcohol or drugs go unnoticed. Studies of women's work also indicate that alcoholism does not affect the performance of women as much as that of men. Most women work in low level jobs, which are often below their potential and capabilities, as a result, performance problems rarely occur. However, if a woman is late, absent or displays poor work habits, it may be interpreted by her supervisor as the result of being a woman and not as a performance problem. Often women in lower level positions are less valued as employees and are thus more likely to be fired for other reasons or to resign before being detected or treated.

Women are also more likely to be discharged for an alcohol or drug problem than men, because they are more likely to hold unskilled or semi-skilled jobs and therefore represent less investment to their company.

EAPs are reporting increased numbers of women referrals, and the B. C. Tel program reports equal proportions of women with alcohol and drug problems as men in the total employee population. This positive trend is a welcome contrast to the dismal reports of past research on service to women in EAPs.

Problems in Treatment

The treatment resources currently available to women with alcohol and other drug problems include the detox centres, outpatient clinics and residential treatment centres in British Columbia, funded by Alcohol and Drug Programs, which accept both men and women as clients. Aurora House in Vancouver, the sole residential treatment centre for women only in the province has 13 beds. Some supportive recovery homes for women, such as Charleford House in Burnaby (6 beds), Peardonville in Abbotsford (18 beds) and Westwood House in Nanaimo (12 beds), offer a sober and supportive environment for recovering women who require a longer term residence, but do not provide intensive treatment. No residential program offers care for children.

Self help programs include AA, Narcotics Anonymous and Women for Sobriety. Some women's AA groups have emerged which attempt to meet women's needs by providing same-sex discussion groups for personal issues, babysitting services, and convenient meeting times.

Women for Sobriety is a more recent addition to the self help network in North America, it has the advantage of being designed by women for women and focussed on the special problems women have in recovery, such as the need for self-worth and the need to expiate guilt. Women for Sobriety groups may stand alone or be associated with treatment facilities.

A woman entering treatment is often in serious financial difficulty. She may be unemployed and her job skills may be minimal. She may be one of the "working poor" and may also have sole responsibility for children. If she is to enter residential treatment, she must be able to make satisfactory alternative child care arrangements. If these are less than optimal her progress in treatment may suffer because she will worry about the children and feel guilty that she is not caring for them herself.

During treatment, women require a supportive environment and counsellors who are skilled at working with women. Therapy that imposes or encourages her to adopt a stereotypical female role can intensify the internal conflict she may be feeling and diminish benefits received from treatment as a whole. She may often have been a victim of sexual abuse, incest, rape or battering and struggling with her identity as a woman and her feelings as a victim.

Child care, financial burdens, physical and mental abuse, cross addictions, low levels of self esteem and the nature of employment are all issues which must be addressed in the treatment of women with chemical dependency.

Fetal Alcohol Syndrome

The consumption of alcohol during pregnancy can cause profound birth defects. The Fetal Alcohol Syndrome (FAS) was first described in 1973 in the English Medical Journal, *The Lancet*. Early studies indicated that the more severe the physical symptoms, the more severe the mental retardation. Later research has indicated that intellectual deficits occur often, even in the absence of the physical characteristics of the syndrome.

Mental retardation caused by maternal alcohol ingestion is preventable.

The committee on maternal and infant welfare in this province recently redesigned the form used by doctors for pre-natal documentation. Questions concerning alcohol ingestion and history must be asked during the patients pre-natal visits. It is vital that physicians use this opportunity to emphasize the risk of fetal alcohol syndrome. Even social drinking can be dangerous.

> It is now well established that a mother *does not* have to be an alcoholic to expose her unborn baby to the risks of alcohol during pregnancy. Nor do alcohol's effects on the fetus have to occur as the full-blown fetal alcohol syndrome; they can occur with variable degrees of severity, and when less severe are referred to as fetal alcohol effects.
>
> Perhaps even more worrisome than the fetal alcohol syndrome are recent reports on the effects of drinking in excess of two drinks (one ounce of pure alcohol) on the unborn baby. As little as two drinks a day may lead to increased risk of abnormalities. This two-drink figure is *not* a numerical average. It refers to the amount of alcohol consumed on any one day. As the amount of alcohol consumed on any given day rises, the risk of abnormalities also increases:
>
> Less than two drinks--Very little risk
> Two to four drinks--10% risk
> Ten drinks--50% risk
> Over ten drinks--75% risk
>
> Based on this information, in the summer of 1977 the National Institute on Alcohol Abuse and Alcoholism issued a health warning, advising expectant mothers not to have more than two drinks a day.
> **Understanding Alcohol Mosby-Medical Library**

The magnitude of the problem has not received the emphasis it deserves. FAS can be prevented, through:

-school education programs
-repeated public information campaigns
-direction from primary care physicians
-pre-natal clinics

Teachers

A teacher is a worker whose product is an altered mind.

The term "unsatisfactory work performance" assumes special significance when applied to teachers, because of their special role in the education and development of our youth. Teachers with substance abuse problems, besides being less effective in their instructional role, are also liabilities as behavioural models for students.

There is nothing to indicate that teachers are any less likely to fall victim to substance abuse than any other occupational group in society. On the contrary, there is cause to suspect otherwise. Studies indicate that children of alcoholic parents tend to gravitate to the helping professions, nursing, medicine, social work and teaching. Children of Alcoholics have a much higher than average risk of becoming alcoholic. Therefore, it is possible that the teaching profession has a higher incidence of substance abuse than the population at large.

Further, teaching can be a stressful occupation and stress is a factor that can contribute to the development of a dependency in a susceptible individual. Notwithstanding the special risks, there is no overall employee assistance program for employees of our school system.

> A school counsellor sometimes becomes aware of a teacher or other employee who has an alcohol or drug abuse problem. Within our school district, as in the case of most, there is no formal process for helping the employee with such a problem. Thus, our only options are either to try to reach the person ourselves, which may be effective if he/she is ready to deal with the problem, or to ignore the situation. If the problem becomes so serious that it impairs work performance, which we know often happens after the home relationships have been seriously damaged, then the employee may lose his/her job. We feel that this intervention is much too late.
> **Courtenay District Counsellors Association**

Teachers are in an ideal situation to detect the unsatisfactory behaviour of students symptomatic of substance abuse or any other severe personal problem. With training, and the existence of a

Student Assistance Program, early intervention would be possible.

Presenters throughout the province saw education as the key element in substance abuse prevention. With special training, teachers can fulfill this need.

Health Care Professionals

> A large number of us came from alcohol-disfunctional families and we seek out the "helping professions"... We are trying desperately to meet the needs that were not met at home by helping others.
> A Vancouver RN

This young woman had just described her family background and noted that both parents are practicing alcoholics; her mother is addicted to over-the-counter and prescription medications. She has a sister who is a practicing alcoholic, married to an alcoholic. The woman had chosen to speak to the Task Force because she had become addicted to narcotics while a practicing nurse and was in recovery. She said she also felt a strong sense of obligation to colleagues who might follow in her path.

She added: "The reason this is so important to know is that most of us are at risk for chemical dependency before we ever think of a career. And then when we do choose we choose areas...where powerful addictive drugs are handled on a day-to-day basis."

Health care professionals have chemical dependency problems that are unique to their calling. As professionals they have a responsibility to maintain their competence to practice. That includes monitoring their own health and taking action when health problems begin to interfere with their ability to give safe care. But when chemical dependency is the illness, the associated denial screens the professional from the reality of the illness. These dependent professionals require intervention and assistance from a committee of their peers. Completely separate from the disciplinary functions of a licencing body, such a committee's role would be to act as an advocate for members with chemical dependency and to intervene before job performance has deteriorated to where disciplinary action is deemed necessary.

The British Columbia medical profession has such a model which represents the professional interests of its members and also assumes the role of bargaining agent with the provincial government. The College of Physicians and Surgeons, responsible for maintaining licencing and standards of practice, is responsible to the public.

To deal with the problem of the impaired physician, the BCMA formed a committee that is separate from and does not report to the College of Physicians and Surgeons. The physician can be approached by a peer in a therapeutic, non-disciplinary fashion with an offer of help.

The following people can contact the Impaired Physicans' Committee when they become aware of a chemical dependency problem in a colleague:

-nursing staff who recognize the problem in a physician;
-hospital administration staff;
-employees of a physician;
...and family, friends or anyone who is aware that the problem exists.

Since its inception eight years ago, the committee has been instrumental in identifying and helping many impaired physicans. Its highest recommendation must be the support it enjoys from among the members of the medical community.

As a group, doctors give lip service to the concept of alcoholism as a treatable disease. On an individual basis, lack of understanding of the disease leaves them extremely uncomfortable and at times incapable of dealing with it on a personal or emotional level.

Health professionals are difficult to counsel. It is difficult for them to accept the role of patient for themselves.

The Task Force endorses and supports the recommendation of the RNABC and the Impaired Physicians Program Committee that a treatment facility in British Columbia specialize in providing care to impaired health care professionals.

Residents of Small Towns

Small towns have small resources. Despite efforts being made by some large employers with operating locations throughout the province, most workers in small communities are removed from local and immediate access to EAP services and/or treatment resources. In the absence of such services personal problems progress unabated making treatment, when finally attempted, more difficult, more expensive and less likely to be successful.

Even where treatment services are provided there are limited numbers of care providers. Budgeted levels of service do not always meet demand. The small town counsellor is particularly vulnerable. Residents of small communities tend to be well known to each other. The counsellor can be tracked down to handle a crisis at night or on the weekend. Personal stress and burnout result. A counsellor's productive time may be significantly reduced by the travel time required to deliver services to outlying communities:

> If we are to...effectively help our employees who abuse substances, we must have EAPs in place. But EAPs alone are not enough; they must have access, and easy access, to adequate resources to provide appropriate treatment for employees using their services. In the Elk Valley, for example, there is only one outpatient alcohol and drug counsellor serving a population base of approximately 22,000 spread over the Elkford, Sparwood, Fernie, Jaffrie areas.
> **Coal Association of Canada**

Isolated Towns

Isolated towns present all of the problems found in the small town situation, with the added complications of geographic isolation. Some employers have attempted to overcome this isolation through travelling EAP consultants, an expensive service beyond the resources of most employers.

Mr. Roy Flower of Quintette Coal Ltd. and Mr. Gerald Hutchison of the United Steel Workers of America, Local 9113 said that remoteness interferes with access to residential treatment. Transportation costs alone can reach $500 for the client. Family involvement in the treatment program is effectively beyond the economic capability of many residents in remote areas.

Employees of Small Business

Employee Assistance Programs are currently available only to a minority of the workforce. Most applications are in large, unionized organizations. Penetration into medium sized firms is minimal. Small business usage is almost non-existent. According to Oksana Exell of Canadian Federation of Independent Business, a majority of workers in the province are employed by small business enterprises. In the absence of an EAP, workers who develop alcoholism or other severe personal problems are at special risk:

> Small business doesn't want to become involved in the problems of an alcoholic. They are more likely to just terminate. They have neither the time, nor the energy, nor the knowledge. Their response is economic. There are people standing in line to take the job. Sending an employee to a treatment centre can present a major disruption in a small firm.
> **Ann White, St. Patrick's House**

> Disclosure by an employee that he has an addiction problem is more likely to mean dismissal if he works for a small business than if he works for a large corporation or government. Small businesses do not have the resources to provide employee assistance programs, nor can they afford to allow an employee time off to get proper treatment. Comprehensive medical programs are not usually available to the small business employee.
> **Jocelyn Wood, Cariboo Friendship Society**

Small business firms seldom have "in house" EAPs because of limited finances and a lack of qualified staff. Third party, contracted EAPs are rare because private consultants are constrained by the law of diminishing returns.

> While there are private consulting services available to employers, designing and delivering cost-effective EAPs for companies with less than 100 employees is very difficult. Designing cost-effective EAPs for companies with only two or three employees is just about impossible.
> **Sarah Billick - "Employee Assistance Programs for Small Employers" - EAP Digest, November - December, 1983**

Economies of scale can be achieved by combining the employees of several small businesses into a consortium. Employers in the Nanaimo area have developed such a cooperative program. In a variation of that approach, MacMillan Bloedel have opened up some of their assessment and referral services to the local community. These initiatives are commendable but their successes may be difficult to replicate throughout the province.

The consortium approach requires educational, promotional and organizational efforts by some person, agency, company or association to go from concept to reality. Consortium EAPs will not come to be spontaneously. The MacMillan Bloedel ARS model requires the pre-existence of an efficient, local EAP infrastructure, with the capacity and willingness to serve outside clients.

George Grant, of Canada Post, told the Task Force that for EAP services to be extended into the entire workforce and the community at large a new model of delivery will need to be created. He suggested that the outpatient counselling services of the Ministry of Health could be the nucleus of the new service.

Outpatient counselling services are currently available to the small business employee but long waiting periods and inflexible operating schedules restrict their use. In-patient residential treatment services are also available to small business employees. The absence of a funded sick leave program may create some difficulties but earned vacation time can and should be used to provide support during such periods. Income can be provided if necessary by the sick leave provisions of the Unemployment Insurance Commission Benefits Program. UIC benefits are available for periods of up to 10 weeks, which is sufficient to cover all residential treatment programs.

Operators of small businesses are typical of the public at large: they have a limited understanding of the nature of addictions and how the illness can be treated. Too often the problem is ignored or, at the other extreme, the troubled worker is terminated. If treatment is attempted, limited access to outpatient counselling or impediments to residential treatment hinder the recovery process.

There is a need to educate small business operators in the EAP process of identification and intervention. There is a concurrent need to make assessment, referral and treatment services available to the small business employee at a reasonable cost in time or money.

EMPLOYEE ASSISTANCE PROGRAMS (EAPS)

Employee Assistance Programs evolved from belief that treatment of the alcoholic could be more cost effective than termination. Today's EAPs address all personal problems that can affect job performance. Their success is indicated by the ever-increasing number of firms adopting the concept.

EAPs are a process leading from the **identification** of a problem, through **intervention** to **assessment**, via **referral** to **treatment**. In a workplace the chain of events is triggered by unsatisfactory job performance. Identification and Intervention are the employer's responsibility; Assessment and Referral are functions requiring specialized knowledge and expertise; they can be provided through third party professionals. Treatment is provided through various community services.

British Columbia Employee Assistance Programs

Successful EAPs respond to the needs of a specific plant, company and community. Troubled employees are a corporate concern. Labour and management design the structures and relationships that suit their circumstances. Accordingly, EAPs vary one from another. There are elements common to all EAPs but it is the differences that make each unique and, in the following examples, noteworthy.

MacMillan Bloedel Ltd.

MacMillan Bloedel refer to their EAP as a "Community Based, Family Assistance Program", "A New Tradition of Caring", and "the course of harmony". Jointly developed, administered and supported by MacMillan Bloedel Ltd., International Woodworkers of America, Canadian Paperworkers Union, Pulp, Paper and Woodworkers of Canada, and Office and Technical Employees' Union, some 2,500 clients were helped by the M&B EAP during 1986.

Stating that "some 20 percent of the work force could benefit from some form of EAP service", Mr. Jim Stimson, Coordinator of the MacMillan Bloedel Employee Assistance Program, explained that the company and the unions are working together, "to relieve and release human suffering". According to Mr. Stimson, of MacMillan Bloedel's 15,500 employees, some 7 to 12 percent have alcohol problems, a further 3 to 5 percent have difficulties with other drugs and an additional 5 to 7 percent have emotional problems.

The MacMillan Bloedel EAP has achieved remarkable success in making the program desirable to its constituents. Ninety to 92 percent of its clients are informal referrals, 40 to 42 are family members, 30 percent are management and salary based.

In 1986 only 60 percent of the problems were alcohol based, compared to 90 percent in 1979. Much of their success comes, we believe, from their unique Assessment and Referral Service.

MacMillan Bloedel had found that their "broad brush" approach increased the expertise required to counsel employees adequately. Such expertise was rarely found in one person. The EAP had to develop a network with specialized community resources. The role and purpose of the EAP changed. The key function of the program became the assessment, referral and follow-up of employees. In effect, the assessment and referral function is that of a dispatcher. It is the intersection between the worksite and a community's health and social service systems. Counselling was left to those who are qualified.

In British Columbia, MacMillan Bloedel have supported the establishment of five community based EAP Client Assessment and Referral Service (ARS) Societies. Each ARS is privately funded by the employers and the unions who use its services. In addition, the ARS is able to receive employees from other organizations within the region on a per capita or a fee-for-service basis, thereby keeping the overall operating costs down.

The MacMillan Bloedel EAP works. By opening up the ARS system to others MacMillan Bloedel and its unions have shown themselves to be good corporate citizens. The ARS system is a concept worth emulating.

B.C. Construction Industry Rehabilitation Plan

The B.C. Construction Industry Rehabilitation Plan has as its goal a healthier and safer work environment for individuals of the organized construction industry. Substance abuse is considered an illness in the plan and employees are encouraged to seek treatment for their problems, not hide them.

> The job site often provides an ideal setting to overcome these obstacles (to detection and treatment). Many

alcoholics will forego their cars, home, furniture, even their families, as long as they can continue drinking. But the threat of job loss may be the spur to treatment - holding on to the job is usually vital to the continuous supply of alcohol.

In fact, employers do have a legitimate right to intervene in the employee's personal behaviour if it interferes with his job performance. Unions too, have an interest in protecting their members' jobs. Faced with the option of having a member treated so he can successfully return to the job, or having him terminated, the choice for the union leadership is clear.

Both unions and management can achieve their goals through the same means - the Employee Assistance or Industrial Rehabilitation program. The aim of the EAP is to stop declining work performance by :

1. Identifying and evaluating the alcohol problems.
2. Helping the person with the problem to get professional treatment.
3. Continuing to support him after treatment.

B.C. Construction Rehabilitation Plan

The employers pay a premium of one penny per man hour into a fund. Mr. Ben Kittila, co-ordinator of the plan explained that the fund covers the overhead and administrative costs including field work and education on job sites. The fund pays the *per diem* treatment costs of all workers going through rehabilitation. The plan is available to all workers, whether or not they are presently working. The fund assists the spouse in attending the family portion of the program, paying for the motel and the equivalent of bus fare.

A penny an hour seems like very small change, yet in the construction industry it has led to a change of life for over 500 people.

B.C. Telephone Company

B.C. Tel has a straightforward policy on treatment for alcoholism and an equally straightforward progressive discipline policy for mood altering substance abuse:

B.C. Tel's Policy re Treatment for Alcoholism

The Company recognizes alcoholism as an illness which is treatable. The purpose of this policy is to ensure that employees having this illness will receive the same careful consideration and treatment that is extended to employees having any other illness. No employee shall report for duty or be permitted to go to work while under the influence of alcohol. Such cases will lead to immediate disciplinary action.

The diagnosis and treatment of alcoholism will be considered as confidential as any other illness.

For the purpose of this policy, alcoholism is defined as an illness in which an employee's consumption of any alcoholic beverage definitely and repeatedly interferes with his job performance and/or his health.

The Company is not interested in social drinking nor does it intrude upon the employee's private life.

The Company recognizes that alcoholism is a progressive disease that can be treated, but that total co-operation is required from the employee.

It also is recognized that relapses may occur as with any other illness. Relapses or slips will be treated on an individual basis and Company action will depend on the employee's interest, attitude and co-operation towards the rehabilitation program.

Sickness Disability Payments will be made when:
a) Employee is working and requires time off for medical and program appointments and is co-operating fully.
b) Employee is unable to work but is following a prescribed course of treatment under medical supervision and is co-operating fully.

The company will impose disciplinary action if the employee does not co-operate by making a conscientious effort at rehabilitation.

B.C. Tel's Progressive Discipline Policy for Mood Altering Substance Abuse

Note: The following policy was designed by the Company and co-signed by the Telecommunications Workers Union. It applies for all employees (Management and Non-Management), and has been in operation since January 10, 1980. As a result of its implementation there has not been a grievance filed. The success in coercively motivating employees to alter their destructive lifestyles associated with various drug abuses has been the most encouraging result of the policy.

Qualification: The substance abuse policy is put into motion only when an employee wilfully allows his or her abuse of any mood altering substance to negatively impact on the job.

Step 1. On the first occasion the employee will be sent home for the balance of the day without pay. The following day the employee shall be given a verbal warning which will also include mention of employee assistance through the Company or the Union.

Step 2. The second incident will again result in the employee being sent home for the balance of the day without pay. The supervisor will issue a written warning, which will be placed in the personnel file with a copy sent to the Union and Employee Assistance.

Step 3. The third incident will bring about a ten-day suspension with another letter outlining the various alternatives for obtaining help.

Step 4. The fourth occasion will bring about a 90-day suspension with rigid return-to-work stipulations. The Company feels that the employee has had three opportunities to resolve any problem without being forced and as this has not produced productive results it must now act assertively to protect the interests of the Company and the employee. The treatment needs for the employee will be determined by an external physician. All aspects of recovery will be reviewed as they apply to the employee, such as a physical assessment by the physician or one appointed, out-patient counselling through the Alcohol and Drug Programs, residential treatment, and of course the ongoing assistance of Alcoholics Anonymous or Narcotics Anonymous. The employee will be required to present letters from the above agencies to substantiate his/her involvement and co-operative participation, not just attendance. If, at the end of 90 days, there are any negative responses the employee will be immediately terminated from employment.

Step 5. The final occurrence will result in immediate termination from employment with exit interview carried out through the employee assistance area. The ex-employee will be told that should he/she wish to be considered for employment by the Company in the future the following must be acted on in order to be qualifying: at least six months absence from the Company, coupled with documents that will attest to the individual's genuine interest in gaining recovery from the destruction of drug abuse; these of course must come from professionals in the field of addictions.

Summary: It is of paramount importance that the Union be involved in all stages of the progressive discipline process whenever the individual is a non-management employee. It is also recognized that there may be parallel disciplinary procedures being carried out with regard to the same employee for issues not known to be substance abuse related.

B. C. Tel, through Doug Hockley, EAP Coordinator, makes no apologies for its hard-line progressive discipline approach. In support of their policy, he said, "I defy the idea that a mandatory referral system doesn't work." He warned the Task Force of the dangers of permissiveness saying that "Such attitudes are tearing down the workplace".

Canada Post

The Pacific Division of Canada Post (B.C. and Yukon) has over 9,000 employees at more than 400 work sites. Their challenge was to provide a service to numerous small offices, spread over a large geographical area. A Referral Agent

(R.A.) model was adopted. According to George Grant, EAP Coordinator, Pacific Division, their R.A. EAP model focuses on one major ingredient for success: the idea of specially trained co-workers or peers offering a confidential referral service to other co-workers affected by alcohol, drugs, legal, financial, emotional, marital or family problems. He said: "Our EAP utilizes another important ingredient: volunteers. Each R.A. has volunteered to help his or her co-workers. No one is being paid, although many are rewarded by feeling they make a positive contribution to their work places." He explained that the R.A. model is accepted by many employees because they know the referral agent.

The Canada Post Referral Agent guidelines state that:

> Referral Agents for the Canada Post Corporation Employee Assistance Program are very special people who have volunteered their time to help their fellow workers deal with their personal problems. A referral agent is selected because he or she is seen as a warm, caring person that is approachable and available for people to talk to. A Referral Agent strictly maintains the privacy and confidentiality of persons with whom he or she talks.
>
> The R.A. guidelines define the R.A.'s role:
>
> 1) To publicize the Employee Assistance Program in their work area.
> 2) To talk privately and confidentially with co-workers who wish to be involved in the Employee Assistance Program.
> 3) To refer employees to local helping resources.
> 4) To engage in simple follow-up contact with referred co-workers.

Sixty-five volunteer referral agents have received an initial three days of training, followed up by refresher training, which allows them to refer their peers to local community resources. The referral agent is not a counsellor, nor is an assessment function performed. The presenting problem is accepted as the prime problem and the referral is based on that problem.

Employee usage is currently running at 3 percent annually. The presenting problems are:

Emotional	22%
Alcohol	21%
Other Drugs	1%
Family	14%
Marital	14%
Financial	12%
Legal	12%
Other	4%
	100%

George Grant acknowledges that the Alcohol and Other Drugs percentages are likely very low, that alcohol and drug problems are being presented in the guise of marital, or financial, or any of the other problems that are secondary to the alcoholism or addiction. However, the troubled individual has begun to reach out for help. Somewhere in the chain of help there may be a proper assessment leading to an appropriate referral to an alcohol or drug counsellor.

Canada Post's use of co-workers as referral agents demonstrates the positive role that peers can play in the workplace.

Peer Support

According to Dr. Rey Carr, University of Victoria, "The peer system that exists in the workplace is a vastly underused or ignored resource. Peers...can be used as a positive force in reducing and preventing substance abuse."

Dr. Carr says that the peer system can be very effective because:

> 1. Co-workers are more likely to talk to each other about a problem they are experiencing;
> 2. There is less likelihood that a co-worker will use the information revealed in such a discussion as part of a performance evaluation;
> 3. Opportunities for actual discussion occur more frequently as a result of breaks, lunches or travelling to and from work together;
> 4. Co-workers are more likely to notice problem behaviours;
> 5. Co-workers are more likely to initiate a conversation with the problem worker about finding some type of assistance;

> 6. There is less likelihood that the worker with a concern will feel humiliated or threatened as he or she might feel at the thought of seeking professional help.
>
> Admitting a problem exists and that it needs professional attention is, for most people, a very difficult step to take. This denial often delays needed assistance to a point where a person is virtually incapacitated or devastated by the problem....Therefore, while professional assistance is necessary for a number of complex problems, the problem is how to bring workers into contact with this assistance....The peer system that exists at work can be a bridge or link to professional help and...should be developed to serve as an adjunct to professional services.
>
> Many workers possess natural helping skills. They listen, they support, they have a way of making suggestions that have influence and persuasiveness... because they have these skills, they are often approached by other persons who want to discuss particular problems. These natural helpers soon realize that while they may want to help their friends, they often do not have the skills to do so. ...These natural helpers are often informal leaders within the workplace and their leadership could be of even greater help with training that builds on their already existing skills.

Dr. Carr points out that the use of peer counselling, peer helping and peer support is viable in almost any organization, including the school system.

The B.C. Construction Industry Rehabilitation Plan recognizes that one of the best "peers" on the worksite could be a recovering alcoholic.

> The government should make a serious effort to make greater use of the experience of recovering alcoholics. This should include the setting up of a training centre in B.C. where recovering alcoholics and others can be trained as counsellors.

A somewhat similar recommendation was received from Mr. Lawrence Henn, who suggested:

> If your Task Force were to run another ad in all the local newspapers soliciting recovering alcoholics who would be interested in helping other people with a drinking problem, you would probably have at least one reply from every company in the area. After interview, and these people are found acceptable, set them up (with management in each company being involved)...to carry the message.

Some firms emphasize the right of employees to refuse to endanger themselves by working alongside the chemically impaired. Mr. Addie of B.C. Hydro advised that:

> We have worked extremely hard to overcome cover-up and denial that oftentimes is in the workplace and which works to frustrate and enable the problems to get worse. We feel we have been fairly successful in that endeavour. We have received numerous reports that employees, because of their concerns over their fellow workers' health and safety have refused to work with someone unless they get assistance. This is important feedback because it indicates that not only are the goals of the program accepted by employees but also that employees accept the need to confront their colleagues to ensure a safe and productive workplace.

We received a similar report from Mr. George Moxham of Cominco. He advised that:

> The matter of impairment at work seems to surface in a crisis situation and usually as a result of other employees refusing to work with the individual who has an excessive drinking problem.

A common sentiment was that colleagues who observe potential problem behaviour in their co-workers are in the best position to encourage them to seek help. Mr. Peter Dowd, Plant Manager of Apollo Forest Products Limited felt that, "Help coming from a co-worker, say with a previous problem, would be very beneficial toward getting other workers on the right track."

The Task Force is in agreement with those views in general and Dr. Rey Carr in particular: "With peer support, employees with work interfering problems would be more likely to seek out and receive the assistance they need."

Identifying the Troubled Worker

The most common queries directed to the Task Force at the open houses throughout the province were: "How do you know when a worker is impaired?" and "What are the signs of alcohol and drug abuse?" Too often the impaired worker, the troubled worker escapes detection, returning to work day after day incapable of doing the job safely or productively.

Marg Fritz of the Phoenix Centre in Kamloops spoke of treating people who consider themselves to be a hazard in the workplace but had not been considered a problem to their management. Those same people acknowledge that (other) fellow workers who were also a hazard in the workplace had not been identified by their management. The issue of identification was also raised by the Association of Labor/Management Administrators Consultants on Alcoholism (ALMACA):

> How can the employer identify such an individual? By having an awareness of the signs of alcohol or other drug impairment and by using that awareness in performance monitoring. The effective Employee Assistance Program includes a training component which alerts supervisors to the significance of the signs. The supervisor's awareness, coupled with active monitoring and documentation allow for early identification.
>
> This method of identifying alcohol/drug-troubled individuals is known as the performance model. Its focus is limited to productivity and safety in the workplace; it does not deal with the issue of use away from work unless that use affects the job. The value of the model is that it allows management to intervene on the basis of legitimate performance expectations and to maintain union support in doing so.

ALMACA spoke of the significance of signs of alcohol and/or other drug impairment. Marg Fritz of the Phoenix Centre described some of the signs:

> It is essential that we become aware of the hazards involved with the prescription drug user, the recreational drug user, the drug misusers and abusers in terms of the effect on the individuals and their ability to perform safely and adequately in a work environment.
>
> Generally speaking, when the use of chemicals progresses to the point it is interfering with the employee's ability to perform, the areas affected include:
>
> Work Performance: Productivity in the workplace may fluctuate from exceptional performance to severe slumps, concentration decreases affecting the quantity and quality of work, carelessness increases with increased errors in judgment and spoilage.
>
> Attendance: Increased frequency of time off, absences may be correlated to prior to or following days off, increases in minor illness, frequent lateness, extended coffee breaks, lunch breaks and leaving early; this behaviour may progress to unexplained absences from work.
>
> Reliability: Chemical abusing employees tend to get sloppy with their work, blame others for shortcomings, desire different workloads or placement, and begin to show signs of economic distress.
>
> Attitudes and Habits: Behaviours often include intolerance, avoidance of supervisor or other employees, sensitivity or over alcohol or drug consumption, anger, suspicion.
>
> Safety: Frequent injury and accidents on and off the job, careless handling and maintenance of machinery leading to accidents and breakdowns, taking chances, straining equipment, lack of safety sense concerning others.
>
> Health: Individual health related responses can be directly related to the drugs used or abused but responses normally seen are increased sick time, complaints of vague illness, hospitalization, inattentiveness, listlessness, poor production.

Marg Fritz then told the Task Force some of the reasons the signs are ignored, not noticed or denied:

In examining the impact on the individual of the use, misuse and abuse of mood altering chemicals it becomes apparent that many employees are functioning in the workplace identified as trouble or troubled employees but they remain undiagnosed as having a problem with chemicals. The inability to articulate the problem is related to a number of factors including: the tendency for fellow employees or supervisors to enable the abuser; the denial by the user of the problem; the vague nature of problems that surface; the inability of supervisors to effectively deal with troubled employees; the lack of information about drugs or sources of help; the problems that surface in unionized facilities where confrontation leads to conflict if an employee is disciplined; the separation of work and home; and the refusal of employers, employees and unions to see the magnitude of the problem. All of these factors lead to the avoidance of an issue that is costing employers millions and employees their lives.

Dr. Ray Baker of Logan Lake is a physician in a "one industry" town. He told the Task Force that identifying troubled workers is not that difficult:

> Identifying problem employees is not difficult... I could do it blindfolded, running my fingers through my file cabinets....Problem employees can be identified by the thickness of their file. The thicker the file, the more likely a problem....These people come to a doctor a lot for other symptoms, insomnia, bad nerves, financial problems...their lives just don't work. These are lucrative patients, because they keep coming back. These are frustrating patients, because as soon as they are confronted, they go to another doctor, which means that their problem will not be identified for a long time. The physician has little leverage in dealing with the problem....Employers often don't want to look at the problem for fear that they will have to spend money on an Employee Assistance Program, yet, the chemically dependent employee is probably losing 25 percent of their salary to things such as arbitration, time lost and low productivity.

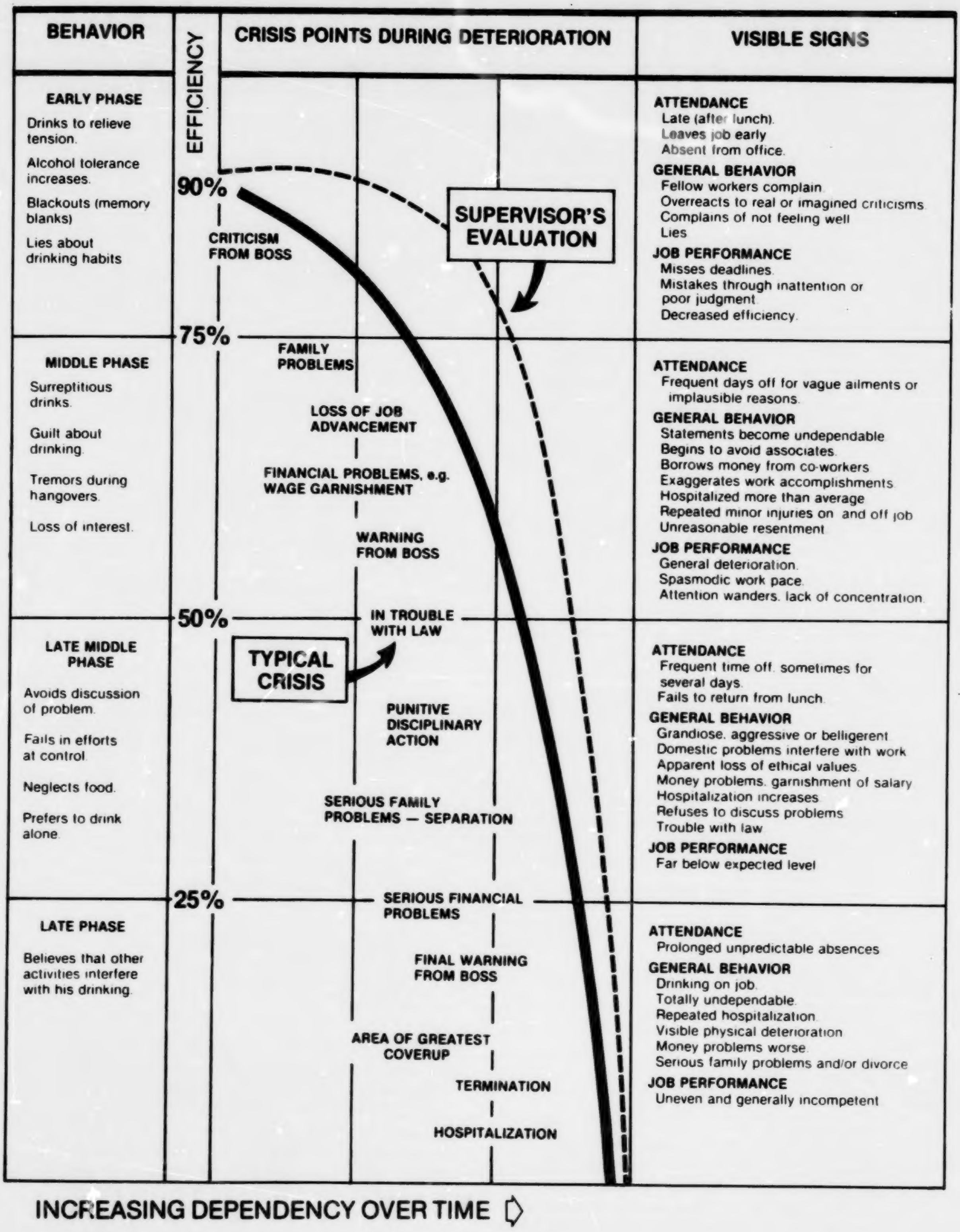
Dr. Baker's viewpoint on the ease of identifying alcohol and drug problems was echoed by Dean Rempel, Director of Clinic, Canadian Forces Base, Esquimalt. He said that it was relatively easy to identify alcohol and drug problems. "Look at problem behaviour and you will be able to find it."

The severity of the problems increases with the degree of dependency and time. CompCare Publications, USA, have graphically demonstrated these relationships in a chart entitled "How an Alcoholic Employee Behaves". The chart makes it apparent that the ease of identification increases as the disease progresses. Their chart is reproduced on page 41, with the permission of CompCare Publications.

Discipline problems may be a symptom of alcohol or drug abuse. Mr. Allan Podsadowski of Alternatives Program, North Vancouver, and others spoke of the relationship between the maturation process and alcohol or drug abuse. The maturation of a young person slows or stops when they abuse alcohol and drugs on a continuing basis. Pain and discomfort are necessary parts of the maturing process. A mind continuously fogged with alcohol or drugs is altered, unable to learn from the experiences of life during that period of time. The opportunities are lost for appropriate adaptation:

> It should be noted that the maturation of a young person stops when they start using drugs and alcohol. So that means, for example, when someone becomes a recovering alcoholic and is no longer using drugs or alcohol, they have to go through the maturation process, beginning at the age level they went heavily into drugs...we then see adolescent type anger in people who haven't gone through all the steps in the recovery process.
>
> When you then transport this individual into the work environment, what you have is a 12 or 13 year old kid in a man's body or a woman's body. Not only have you got the lack of maturation but you also have their impairment due to their abuse of alcohol or drugs. Your expectation of them is that they are adults because they look like one. But you have all of the crazy quirks that go with a teenager...you can't get a 12 year old to cut the grass. You can't get an adult with a 12 year old mentality to have the work ethic....The discipline problems are worsened

How an Alcoholic Employee Behaves



BEHAVIOR	EFFICIENCY	CRISIS POINTS DURING DETERIORATION	VISIBLE SIGNS
EARLY PHASE Drinks to relieve tension. Alcohol tolerance increases. Blackouts (memory blanks) Lies about drinking habits	90%	CRITICISM FROM BOSS	**ATTENDANCE** Late (after lunch). Leaves job early Absent from office. **GENERAL BEHAVIOR** Fellow workers complain. Overreacts to real or imagined criticisms. Complains of not feeling well Lies **JOB PERFORMANCE** Misses deadlines. Mistakes through inattention or poor judgment. Decreased efficiency.
MIDDLE PHASE Surreptitious drinks. Guilt about drinking. Tremors during hangovers. Loss of interest.	75%	FAMILY PROBLEMS LOSS OF JOB ADVANCEMENT FINANCIAL PROBLEMS, e.g. WAGE GARNISHMENT WARNING FROM BOSS	**ATTENDANCE** Frequent days off for vague ailments or implausible reasons. **GENERAL BEHAVIOR** Statements become undependable Begins to avoid associates. Borrows money from co-workers Exaggerates work accomplishments. Hospitalized more than average Repeated minor injuries on and off job Unreasonable resentment **JOB PERFORMANCE** General deterioration. Spasmodic work pace. Attention wanders, lack of concentration.
LATE MIDDLE PHASE Avoids discussion of problem. Fails in efforts at control. Neglects food. Prefers to drink alone.	50%	IN TROUBLE WITH LAW PUNITIVE DISCIPLINARY ACTION SERIOUS FAMILY PROBLEMS — SEPARATION	**ATTENDANCE** Frequent time off, sometimes for several days. Fails to return from lunch. **GENERAL BEHAVIOR** Grandiose, aggressive or belligerent. Domestic problems interfere with work Apparent loss of ethical values. Money problems, garnishment of salary Hospitalization increases Refuses to discuss problems Trouble with law **JOB PERFORMANCE** Far below expected level
LATE PHASE Believes that other activities interfere with his drinking.	25%	SERIOUS FINANCIAL PROBLEMS FINAL WARNING FROM BOSS AREA OF GREATEST COVERUP TERMINATION HOSPITALIZATION	**ATTENDANCE** Prolonged unpredictable absences **GENERAL BEHAVIOR** Drinking on job. Totally undependable. Repeated hospitalization. Visible physical deterioration Money problems worse. Serious family problems and/or divorce **JOB PERFORMANCE** Uneven and generally incompetent

> because they think like a child and so much of a child's thinking is subjective and egocentric....Discipline systems designed for adults don't work with children.

The text, "Marijuana Alert", published by McGraw-Hill, spoke of this phenomenon, quoting a psychiatrist, Dr. Mitchell Rosenthal:

> The focus of my concern is pot's capacity to induce regression and, at times, irreversible immaturity.
>
> A sizable number of our young people will not mature as they should, will not make the intellectual gains they should during their growing years, will not become the capable and productive citizens our society needs. Instead, we can look forward to a growing population of immature, under qualified adults, many of whom will be unable to live without economic, social and/or clinical support. We will have, in time, an unmanageable number of emotionally, socially and intellectually handicapped citizens.

Industry and labour must be concerned about teenage alcohol and drug abuse. The youth of today are tomorrow's workers. Some companies recognize the problem and offer help through their EAP. Doug Hockley of B.C. Tel said, "I deal with the sons and daughters of our employees and they are out there using and they are coming to the workplace some day."

The Task Force believes that it is in everyone's interest to become proficient in the identification of the troubled worker. You have to find the person with the problem before an offer of help can be given. Job performance remains the key identifier. The Task Force agrees with ALMACA when they state that, "...the most appropriate format for dealing with abuse is through documentation of job performance and constructive confrontation leading to treatment of the abuser."

Intervention

The troubled worker gives off more and more signs of distress as the disease progresses. Too often the growing circle of people affected by the alcoholic enables the process to continue. Mr. Lloyd Lundin, Co-Chairman of the EAP Committee, Northwood Pulp, believes the major contributing factor is the problem of cover-up by family, friends, fellow workers, union personnel, management and physicians. He said there is a fear of labelling others as alcoholics or addicts because of the implications of the label, so no action is taken.

Mr. Angus Davis of Fraser Lake, described the cover-up process:

> Just like the supervisor who will discuss everything under the sun so he won't have to mention the word alcoholism or addiction, we have the terrible tendency to coverup the abuser's actions. We protect him.
>
> Someone may have a terrible hangover and be too sick to go to work. This individual gets the spouse to phone the boss and say that he has the flu - a cover-up.
>
> Dad may be half smashed down at the bar, but if someone is looking for him at home, his wife may say that he is working - another cover-up.
>
> Bad cheques are made good for the abuser - still another cover-up.
>
> There are just as many cover-ups as there are circumstances. We place ourselves in a compromising situation when we cover up for these people because we have allowed their sick behaviour to determine our lives.
>
> In industry and at home, there is so much covering up for the sick people...this does not help the problem. It just makes it worse. The abuser is calling the shots and others are being dragged down to his level.
>
> I think that the more that people can be made responsible for their own action, the greater the realization will be that a problem exists.

Ann White of St. Patrick's House also commented on the cover-up originating with the troubled worker themselves. She said that many of her clients will not tell their employer or a prospective employer that they have a problem with alcohol. When asked why, they responded that it was because of a fear of rejection, not being given a second chance, a fear of loss of trust, and a fear of being labelled a problem employee. Unless shown otherwise, most workers believe that employers do not want to have anything to do with a problem worker. Ann White urged employers not to lose sight of the fact that they could be saving a human life through intervention.

The text, "A Training Course for EAP Referral Agents", published by Health and Welfare Canada, summarized the steps necessary for a successful intervention. They apply equally to a family intervention or a workplace intervention:

> There are several prerequisites for successful intervention. First, (the person) must have knowledge and understanding of chemical dependency. He or she needs to recognize that alcoholism is a progressive and devastating illness...an addictive condition which is treatable.
>
> The second important factor in successful intervention is that a concerned individual takes steps to deal with the problem. The affected individual rarely takes the initiative to do anything about his or her excessive drinking behaviour. This is because denial of any dependency is a key feature of the illness...the individual's social contacts are not likely to intervene in the situation until the alcoholic's behaviour is simply intolerable. They may be ignorant about the early stages of alcoholism, may fear a hostile reaction if they say anything, or may feel it is none of their business. The relevant persons in the individual's social world contribute to denial of the illness by closing their eyes or tolerating the behaviour.
>
> Because of the strong role of denial in alcohol dependence, waiting for the individual to be intrinsically motivated usually implies waiting for disaster to occur. Internal motivation or acceptance of help is not usually present at the early stages of the illness. Rather, it tends to develop during, rather than before, the treatment process. Pressure can be exerted on the individual before health, job and family relationships are severely affected. In fact, research has suggested that the earlier the intervention occurs, the more likely is the chance of successful outcome.
>
> The individual with an alcohol dependency experiences crisis in his or her life on a routine basis. A crisis occurs anytime harmful consequences result in a person's excessive or inappropriate use of chemicals... the key to successful intervention is to take advantage of these crisis situations in order to convince the chemically dependent person to take action to deal with the problem. This can be accomplished through the process of constructive confrontation.

Christine Rinaldi, an Alcohol and Drug Counsellor in Cranbrook, said that "recovery and rehabilitation are directly related to early recognition and early treatment" and that, "many individuals who seek treatment have been encouraged or coerced by their families."

ALMACA described constructive confrontation in the workplace:

> The Intervention
> Work performance, attendance, and behaviour within the work setting continue to provide the objective base for an intervention. Intervention is achieved through the use of constructive confrontation. Constructive confrontation involves creating a "bottom line" for the employee that the organization is willing to stand behind and that motivates the employee to take the necessary steps toward treatment. Constructive confrontation is most effective when there is an agreement between the parties involved (labour, management, EAP) as to the "bottom line". The "bottom line" may include job termination, suspension until recovered, suspension for a specified time, etc. It is critical that the required treatment plan and any consequences of not complying with the treatment plan, or with post treatment expectations of work performance, be clearly and concretely described.

Roy Flower, Industrial Relations Coordinator, Quintette Coal and Gerald Hutchison, Equipment Operator, Quintette Coal, a United Steelworkers Union representative, urged companies and unions to cooperate fully in the intervention and rehabilitation process of troubled employees. Gerald Hutchison described what union members can do on their own without involving management. For example, he said, the EAP committee member, who is also a union member, can do a lot of one-on-one intervention with individuals without involving management.

Mr. Hutchison said, "I don't care what I have to do to get the worker help, I'll do it because I definitely believe in the intervention process. Intervention is critical. As a local we have a responsibility to our membership. We have to maintain responsibility for our action. Our members have a responsibility to themselves."

Mr. Marc Lavertu, Probation Officer, Powell River Corrections Branch, felt that "help should be available even to those who are totally opposed to getting help for their problems."

Crestbrook Industries of Cranbrook, in their submission to the Task Force, combined the concept of intervention with that of individual responsibility:

> Employers, union officials and pertinent government agencies, including the Workers' Compensation Board, must develop and deliver to the work force, on an ongoing basis, the message that the use of alcohol and drugs in the workplace cannot, and will not, be tolerated. We must all be educated to the fact that substance abuse is neither morally, ethically or socially acceptable on the job site.
>
> This educational material should spell out not only the necessity to stop the use of drugs and alcohol in the workplace but to convey the message of individual responsibility - responsibility of supervisors to address the problem objectively, responsibility of fellow workers and union personnel to avoid a misguided sense of concern for the problem employee by covering up and making excuses for him, and most importantly, responsibility of the individual to avoid abuse of alcohol and drugs in all facets of life.
>
> We believe that where there is an effective Employee Assistance Program in place, both employees and employers will benefit...no matter how the program is structured, its philosophy must focus responsibility onto the problem employee. The employee must recognize and accept his or her problem as one that they as individuals must correct. Until these people accept the fact that they have a problem and that they alone must correct it, the opportunities for success are extremely remote.

The intervention, the constructive confrontation, is sometimes described as "tough love". A recovering alcoholic from Port McNeill talked about the way tough love was used on his recovery. He felt that he needed that approach to get through his denial. He cautioned against being weak in the confrontation process. He said, "Don't say, stop drinking for a year. Because that's all he'll do, at the end of the year he will start again."

Dr. Abraham Twerski, in his text, "Caution - Kindness Can Be Dangerous to the Alcoholic", talked about the theme of his book and his attitude toward the alcoholic.

> At times it appears to be punitive, in some places it may appear to be callous, and yet the underlying theme is one of care, concern, sympathy, and empathy.... In virtually all instances, there is nothing that you can do to change the alcoholic. All that you can do is to stop the kind of behaviour that prevents the alcoholic from feeling the impact of destructive drinking soon enough to save himself or herself and, it is hoped, preserve the family unit.

Dr. Twerski added that "job leverage is one of the most potent forces available to induce an alcoholic to accept treatment." The Task Force was asked at one of the informal meetings if compulsion was effective; was there a difference in recovery rates between voluntary referrals and formal referrals? Jon R. Weinburg, PhD, Hazelden, USA, reported:

> Involuntary treatment of an unmotivated alcoholic has been shown to be effective in many cases. Contrary to popular belief, motivation is not essential prior to treatment. There is abundant evidence that many, if not most alcoholics become motivated during, rather than before treatment. In fact, many so-called voluntary patients only submit to treatment as a way of coping with strong social pressure or other non-legal forms of coercion. Available studies show that treatment results are equal for voluntary and involuntary patients. One may also remember that alcoholism is generally fatal, and all but the most extreme civil libertarians believe in society imposing treatment when the probable alternative is death.

Mr. Alan Podsadowski related his experience with clients faced with job loss:

> Although...many employer referrals can result in cases where the chemical dependency is in an advanced stage, one key factor makes this type of client desirable. That is, when an individual finds his or her job on the line, their motivation for major behavioural change can be substantial. I have witnessed numerous situations where spousal threats of abandonment and/or physician's warnings of physical deterioration did not seem to provide the necessary motivation for change. The harsh realization of imminent job loss, however, has often provided the convincing factor necessary to save job, family and, in some cases, the person's life.

Mr. Jeff Talbot, Counsellor, Alcohol and Drug Programs, Kitimat, also advocated formal referrals. He said, "EAPs are the most effective way of ensuring a life style change. Loss of employment is a greater motivator than loss of family or friends." Mr. Talbot emphasized that the structure of the EAP is important to success. He explained that the employee needs to know very clearly and concisely where he is in the referral process. That would include knowing the penalties for failure and the rewards for success. He recommended that this kind of understanding is best expressed in a contract form, whether it be in writing, or by practice, following from a clearly articulated EAP. The terms of the contract should include the behaviour expected of the individual, what would happen if the contract is breached, how relapse would be handled, and how the joint union/management program relates to the process.

Mr. Talbot recommended that even those who are terminated during the process for failure, should be encouraged to address their problem after termination so that they could become eligible for rehire. He warned of threats that are not carried out. If the work force perceives that the formal referral is meaningless, that a refusal to comply does not bring any sanctions, the EAP could be counter-productive. It would be another form of enabling.

That viewpoint is shared conceptually by Ken McRae, Chairman, Canadian Paperworkers' Union, and Deach Tetarenko, Employee Relations Supervisor, Alberni Pulp and Paper. In their joint presentation to the Task Force they said, "You have to have oomph in the program." Mr. McRae explained that it took some time for them to realize that the program must be aggressive, then, "one of our alcoholics died. That got our heads out of the sand."

Their program is a three-step plan with the union involved from the first step onwards. An official communication is made to the worker after each step in the form of a joint letter. The second communication tells the troubled worker that, "If he screws up once more, he's out of the program." And, Mr. McRae said, "He knows what the situation is." They described their program as a success with the biggest supporters those who have been through the program. They help even those who have been terminated, "even when they're out the door we don't give up - we have rehired four people who have been terminated. Rehired persons are on a 12-month probation."

The Task Force agrees with Mr. McRae and Mr. Tetarenko: a program requires "oomph" to make it work. At some point in the intervention process, if the problems continue, the transition from informal suggestion to formal recommendation must occur. The troubled worker must face the consequences of personal inaction, especially when, as shown, the very act of termination may be the final incentive required for the troubled worker to accept help.

Assessment and Referral

The assessment and referral functions are considered to be the key to an effective EAP, the intersection between the worksite and the community's health and social service systems. Assessment is required to identify prime problems so that treatment can be effective. It is futile to treat stress as the cause of unsatisfactory behaviour if that stress is only a symptom of chemical dependency. The referral function becomes important after the prime problem has been identified. Should alcoholism be the prime problem it may be inappropriate to recommend six weeks in a live-in treatment centre if outpatient counselling could do the job just as well. A course of treatment is negotiated and a referral to treatment is made.

According to Ruth Shell, a professional EAP counsellor, there are five key goals in accomplishing the mandate of assessment, brief counselling and referral:

-to give the client a positive experience as a helping process
-to diffuse the presenting crisis

- to focus on key issues and frame the direction of work
- to reframe the client's focus from other to self
- to direct the client to other resources for further help and resources.

The importance of a proper assessment can be illustrated through the experience of B.C. Tel. Alcoholism, through its symptoms, mimics other illnesses or problems. Troubled people often enter the EAP process believing that they have a "stress" problem, or a "legal" problem and find, during assessment and short term counselling, that their prime problem is alcoholism.

The following chart illustrates the shifting that took place at B.C. Tel during 1986:

1986 Issues	Percent Presenting	Percent Actual
Alcohol and other Drugs	25	41
Personal Stress	20	11
Relationship	18	17
Emotional	12	8
Other Illnesses	5	5
Legal	4	2
Career	9	9
Financial	2	2
Suicide	1	1
Assaults	1	1
Day Care Problems	1	1
Bereavement	1	1
Retirement	1	1
	100%	100%

Arbitral Jurisprudence

Unless a worker's chemical dependency is detected early and treated successfully, there will be a major deterioration in both performance and behaviour. The employer's reaction may lead to conflict with the worker and the union and ultimately arbitration.

Arbitrators and, increasingly, employers are recognizing that alcoholism and other drug dependencies are illnesses and are not by themselves grounds for discharge.

> We realize the nature of the problem is characterized by denial, rationalization and relapse. Therefore, chemical dependency should initially be treated in a non-culpable manner.... Before discharge, a person [should] be afforded reasonable opportunity to change.
> **Coal Association of Canada**

There is a developing notion of employer responsibility to encourage rehabilitation of employees who are alcoholic or drug addicted. The Canadian Human Rights Commission spoke on this concept in their paper "Analysis of bona fide occupational requirements issues and guidelines with respect to the inclusion of mental disability and alcohol or drug dependence in the Canadian Human Rights Act."

> Human Rights is a balancing exercise. It seeks to balance, in an employment context, the right of a person to possess an opportunity to work which is equal or equivalent to the opportunities of other persons, regardless of disability, with the right of employers to expect that the essential function to the job will be carried out in a reasonably safe manner with no undue hardship to business operations... the task is always to strike a balance between these two rights....

> In the case of the alcoholic employee, the arbitrator now incorporates into the Just Cause standard, the requirement that the employer assess the employee's potential and willingness for rehabilitation before discharging him. Practically speaking, this means that the employer must have given the employee a chance for rehabilitation. If the employer discharges the employee without having done so, the discharge will not be sustained.

> The prerequisites [prior to the discharge of an alcoholic employee] are as follows:
> 1) That the employee be informed as to the nature of his illness.
> 2) He must be directed or encouraged to seek treatment.
> 3) He must refuse treatment, or
> 4) He must fail to make substantial progress over a considerable period of time.

A number of arbitration decisons dealing with alcoholic employees have

> interpreted the requirement that the employee be directed or encouraged to seek treatment as entailing, depending upon the circumstances, employer assistance in the form of leaves of absence, payment of treatment costs, granting of sick leave benefits, or the like. The same decisions also indicate the arbitrators do not expect employers to tolerate indefinitely alcoholic employees who are incapable of carrying out their basic responsibilities. Thus, a form of mutual accommodation is inferred in these decisions which state that where employers have fulfilled their obligations with respect to encouraging an employee's rehabilitation and the employee's misconduct continues, either because rehabilitation efforts have failed or the employee proves to be unsalvageable, an employer's discharge of the employee may be sustained.

EAPs reduce arbitration and other labour relations litigation as a result of:
1) Self referrals and early intervention leading to recovery before unsatisfactory work performance becomes chronic.
2) Recognition of the EAP process by fellow workers, union officials and the employer as an alternative to the adversarial approach.
3) The consistency of the process, which prevents procedural errors in dealing with troubled employees.

Current Problems

Presenters throughout the province were consistent in claiming EAPs as the most effective way to combat alcohol and drug abuse in the workplace. Their message was that their should be more EAPs, and that some existing EAPs should become better. They described the following problems as impediments to the maximum utilization of EAPs:

Availability
EAPs are currently available only to a minority of the workforce. Most applications are in large, unionized organizations. Penetration into medium sized firms is minimal. Small business usage is almost non-existent.

Quality Control
The rapid growth of EAPs has created a demand for a new professional, the EAP practitioner. Chris Bitten, CEAP, B.A., Western Canada Chapter, ALMACA Certification Committee, told the Task Force of the need for this new industry to define the "core technology" of EAPs, to provide a mechanism for ensuring basic knowledge and measuring continuing education and to standardize employee assistance. There must be, he said, a bench mark qualification to aid those hiring EAP personnel in the selection process:

> ...There comes a time when it is necessary to determine what knowledge and competencies are essential to satisfactory practice, what the components of a good EAP are, and what the parameters of the profession are.
>
> Those who have pioneered in this emerging field come from astonishingly diverse backgrounds. They may have little or no university education; they may have several degrees. They may have gathered the necessary knowledge from a variety of sources. Many of the formative concepts, basic workplace strategies, skills and knowledge have been the result of a lot of trial and error...hard work often done by recovering alcoholics who have translated the AA twelfth step (helping other alcoholics to achieve sobriety) into an informal program in their place of work. As time has gone by, the EAP field has tended to attract those with more formal types of training such as social workers and psychologists. Theory and education have tended to follow practice. Practice that has been tested under fire in highly demanding workplace settings.
>
> Like any other emerging profession, EAPs have had "growing pains" and their share of developmental issues. There are now a few post-secondary institutions that provide partial training for this specialty. However, as yet, there is no degree or certificate that the academic world has specifically designed for this work. This is one problem in setting standards.
>
> Another is that many of the new entrants into the field had little familiarity with or training in identifying and helping the chemically dependent employee. This trend sometimes resulted in a change of the EAPs focus away from dealing with dependency and towards such areas as

> employee wellness, stress management, etc. Without a specific focus on chemical dependency, the major problem in the workplace is not going to be addressed. Working with chemically dependent people is a profession in itself: special skills and knowledge are essential. Yet nearly anyone can describe him or herself as an employee assistance practitioner and many businesses, government agencies and unions which hire EAP personnel had very different ideas about what qualifies someone to perform this work.

Mr. Bitten explained that ALMACA started to design a certification program in 1984 and found that despite the wide diversity of practitioner backgrounds there was a strong consensus on the elements of EAP practice. ALMACA describes the objectives of certification as follows:

> To promote competency in Employee Assistance programming by:
> 1. Providing a standard of requisite knowledge in EAPs.
> 2. Recognizing formally those individuals who meet the standards established by the Employee Assistance Certification Commission.
> 3. Encouraging continued professional growth in Employee Assistance programming.
> 4. Establishing, measuring and monitoring the level of knowledge required for certification in Employee Assistance programming.
> 5. Assisting employers, labour unions, health care providers, educators and other practitioners, as well as the public, in identifying qualified employee assistance professionals.

Mr. Bitten said that the ALMACA credentialling is especially significant in British Columbia because the province lacks a certification program for alcohol and drug counsellors. The Task Force agrees with that observation. It is our view that the ALMACA certification program is a very positive step towards increasing the quality of EAP services throughout British Columbia.

Multiple Worksites

Large, multi-branch organizations have difficulties servicing worksites in small towns, or even in branches in locations other than the site of their EAP office. Distance often provides a barrier to face-to-face meetings during crisis situations. The problem must be addressed by telephone communication or is put on hold until the next visit by the EAP practitioner.

This problem could be partially offset by using the services of private EAP practitioners at out of town worksites. However, as one EAP coordinator told the Task Force, that would cost more money and the EAP budget just doesn't allow for it.

Treatment Resources

Effective EAPs follow a logical sequence of events. Identification is followed by intervention which, if successful, leads to the assessment of the troubled worker. A course of treatment is then negotiated and a referral to treatment is made. The system breaks down at this point if the treatment resources are not available.

Even under the best of conditions a delay in admittance to a Residential Treatment Centre can be expected. The delay presents a problem but the problem is not critical if outpatient counselling can be provided during the waiting period. Should outpatient counselling be unavailable the severity of the problem varies directly with the length of delay. The Assessment and Referral Agent will, of necessity, step into the breach and provide short term counselling, a form of crisis management. Many Assessment and Referral agents are not qualified for this role.

Scope of Program

Some programs are limited in the number of personal problems covered. Some are designed for alcohol only. Others may be intended to provide a "broad brush" service but the practitioner may be skilled only in handling chemical dependency, thereby effectively limiting the program's scope.

Some programs are truly Employee Assistance Programs in that they provide services only to the employee and not to the family. Since many personal problems involve the family, employers limiting their programs to the employee are also limiting the effectiveness of the program.

EAPs that provide a referral service only are not as effective as programs offering a combined assessment - referral service.

On Site Facilities

On site facilities may be counterproductive. Workers may feel that they would be spotted using the EAP facility and their anonymity would be lost. There could be reluctance on the part of family members to use the service if they have to go to a company building to do so. Off site facilities are probably more likely to be used.

Combined Responsibilities

The EAP function may be added to the existing duties of the individual. Other duties may make the EAP practitioner unavailable for varying lengths of time. A presenting crisis may have to be put on hold. There could be a conflict of interest between the individual's regular duties and the EAP role.

Conflicting EAP Duties

Arlene Keis, M.Ed., R.S.W., CEAP, Coordinator, EAP, Canadian Airlines International, detailed the potential for conflict-of-interest that exists for Employee Assistance practitioners in fulfilling their EAP duties. Ms. Keis told the Task Force that EAPs evolve from an organization perspective, thus the organization itself is a primary client as is the troubled employee. A potential for conflict-of-interest exists because of the dual priority; the demands of the troubled employee in terms of time and costs often cause the needs of the organization to be held in abeyance:

> I have observed (subjectively) that an EAP's effectiveness... is in direct relationship to the effort and time put into the organizational work.... For every hour that an EAP spends counselling one client, there is one hour taken away from influencing one or one hundred managers or shop stewards who can influence hundreds more (i.e. by identifying and referring them). In essence, the difficulty is not found in the clinical aspects of EAP, but in getting them to EAP in the first place....
>
> Too many times the EAP practitioner views him/herself as a clinician accepting clients from an exclusive source (the organization). ...This approach lends itself not to an Employee Assistance Program but an employee, counsellor/therapist or psychologist. It does not value the organization and its members as being a target for intervention or change. It does not envelope the concept of EAP as consultant, coach, trainer, facilitator or resource. It may enable the organization to view the EAP as a frill... the EAP stays locked in an office all day, seeing employee clients and spends little or no time to attending to the organization as clients.
>
> In my opinion, the EAP practitioner would be ideally better off to, insofar as possible, divide the responsibilities of organizational work and counselling work. The strengths and interests of the manpower available should be channelled, as much as possible, into the two areas.

Labour Relations Climate

Potential EAPs have been thwarted by a poor labour relations climate.

Educational and Promotional Materials

The availability of educational and promotional materials varies from employer to employer with the organization size and budget making the differences. There is a lack of multi-purpose, generic materials available for use.

Developmental Costs

The necessary up-front investment required has acted as a formidable barrier to the growth of the EAP concept.

TREATMENT

Alcohol and Drug Programs

Most services pertaining to alcohol and other drugs in the province are provided by or funded through the Ministry of Health's Alcohol and Drug Programs (ADP). They began in the 1960s as a narcotics foundation and a separate alcohol foundation; they were amalgamated into the Alcohol and Drug Commission in the early 1970s. The ADP was established in 1983.

The ADP services, within the Ministry's Community Care Division, take care of planning, funding and coordinating treatment and prevention programs in five administrative regions:

- Lower Mainland
- Fraser Valley
- Central and Southeast
- Northern
- Vancouver Island and West Coast.

In 1986, 25,000 people used the 72 services which are funded directly or indirectly by the ADP.

The system provides a continuum of care through three components:

1. Detoxification Centres

Their purpose is to provide a safe, supportive environment during withdrawal or acute intoxication, to assess the individual's need for follow-up treatment and to help them to enter programs.

There are seven detoxification facilities in the province, with 189 beds. Vancouver has three, with a total of 106 beds. The remaining facilities are in New Westminster, Prince George, Kamloops and Victoria.

During the past 20 years the changing pattern of alcohol and other drug use has necessitated more intensive, sophisticated care in detoxification facilities. Many are staffed with trained workers, nurses and attending physicians. Most provide education about chemical dependency to the clients and have a link to community hospitals.

The Great Northern Way Centre in Vancouver was developed in response to the urging of the city police to get rid of their "drunk tank". Jail is not an appropriate

The Great Northern Way Centre in Vancouver was developed in response to the urging of the city police to get rid of their "drunk tank". Jail is not an appropriate

place to supervise detoxification, which can have serious, sometimes fatal complications.

The province lacks adequate detoxification facilities. Presenters felt that such services could be developed in local hospitals if they were linked directly to the ADP system and staff received training. Several community hospitals have developed admission policies for detoxification and, perhaps equally important, they have developed links with local out-patient clinics. Among them: Salmon Arm Hospital, Kelowna General and Victoria General.

The Greater Victoria Hospital Society has developed a team concept that the Task Force finds worth emulating. A physician, nurse and social worker, trained in the subject, intervene and refer on behalf of specific patients. The team provides education for hospital staff, helping them with earlier recognition of dependency in patients.

> The Task Force should recommend the creation of an integrated service which combines detoxification and residential treatment. Many who enter residential treatment without being detoxified are unable to benefit from the treament until well into the program.
> **Registered Nurses Association of British Columbia**

> [If a physician] sends [a patient] to the Lions Gate Hospital for "tests", in a sense that is enabling. It is a form of enabling to euphemistically admit people to a hospital for "tests", when in fact what you are doing is admitting for detoxification. There is some value in using a detox centre if one is available because it demonstrates to the patient how far the problem can go if it is not dealt with.
> **Alan Podzodowski, Alternatives, North Vancouver.**

> Detox can be done locally in all hospitals and that is the proper place for it to be done.
> **Hugh Tarbet, Kelowna**

2. Outpatient Clinics

The outpatient component is crucial to the success of the system of care for chemically dependent people. The clinics serve as a broker for services, perform assessment and referral functions and provide treatment through counselling and group work.

Virtually unanimous praise was expressed for the existing outpatient system and its staff. They provide treatment through counselling and group sessions and must perform community development work. Presentations confirmed that the system is overloaded and staff are underpaid. It was made clear also that outpatient treatment is cost effective and may offer advantages over residential treatment.

The 42 outpatient facilities in British Columbia range from large urban clinics with a full complement of professional and support staff to rural offices with one counsellor. There is no charge for outpatient services.

> The outpatient counselling service is the keystone [of the] system of care. This keystone is being hampered by both insufficient funds and overworked, undernourished staff. Long waiting lists diminish both client and referrer motivation for this initial treatment.
>
> The outpatient counselling component of [the] system requires extensive improvement. I urge this Task Force to request our provincial government to provide further and more stable funding to this outpatient counselling service.
> **George Grant, Canada Post EAP**
>
> The client must try to maintain appointments at outpatient centres that are overloaded and struggling to keep up with demand.
> **ALMACA**
>
> The ADP counsellor is grossly underpaid. The Alcohol and Drug Counsellor is the only resource in town. This means she is doing all types of counselling, including marital counselling, social counselling etc. There are no psychologists or psychiatrists in the community.
> **Roy Flower, Gerald Hutchinson, Tumbler Ridge**

It was suggested that the severe lack of resources in the "true" north of the province could be addressed by establishing a mobile team of two counsellors - one for addictions and one for families - with home base in Whitehorse and co-funding by the Alcohol and Drug Services in Whitehorse and B.C.'s Ministry of Health.

A common observation was that the name Alcohol and Drug Programs "on the door" is a barrier to entry. Many who need the services are unwilling to go voluntarily because of the stigma associated with "alcoholism", drug addition" and "dependency". Furthermore, when a person is referred to an ADP, in essence a diagnosis has been made, usually without a proper assessment. The Task Force was convinced that ADP outpatient clinics probably attract half of those who would come for help if the name were changed.

3. Residential Treatment

There are two types of residential centre, both under an individual non-profit society with funding from ADP. The **supportive recovery home** is a "halfway house" for those who have been detoxified, usually staffed by people in recovery themselves. Techniques include group discussions, information sessions and access to AA. Clients may stay for several months. Often they are unemployed and have been damaged socially and physically by their illness.

The **residential treatment centre** provides trained staff who conduct intensive treatment courses (28 days to six weeks) for people who are working or can seek employment. Clients here also are accepted only after detoxification. Trained staff are supervisors and counsellors.

Some centres base their programs on the AA perception of chemical dependency as a disease that is treatable, with recovery dependent on abstinence. A second group places emphasis on the clients' accepting total responsibility for themselves, generally discounting the illness concept.

> Each centre has its own ground of learning and helping - and it is better to think of them as learning centres - but there are basically two types, those who use an Alcoholics Anonymous based program and those who use various forms of group therapy to help the client change his

> behaviour and lifestyle. Most centres are in this latter category. Maple Ridge in Haney is based on AA principles, Dallas House in Victoria combines the two approaches.
>
> Advantages of the Maple Ridge Approach
>
> More than anything else the alcoholic needs identification and hope. Recovering alcoholics can provide this and, at Maple Ridge, all the counsellors are recovering alcoholics. They have "been there" themselves and can relate to the client, but can also see through the lies and denial. New clients join a therapy group where some in the group have been in treatment three or four weeks and can help them along. There is a valuable one week family program, and AA follow-up after treatment.
>
> Advantages of the Behavioural Approach
>
> These centres rely heavily on group therapy, where the entire group comes into the program together and discovers and grows together. These centres probably work best if the client has several months of sobriety and is able to handle the heavy therapy sessions. But clients can come in directly after detoxification. Some of these centres do have family programs.
> **B. C. Construction Industry Rehabilitation Plan**

The ADP funds nine recovery homes (213 beds); two of the homes are for women. There are nine residential centres; only one (Aurora House, Vancouver) is for women exclusively (13 beds).

The effectiveness of residential treatment vs. outpatient treatment was questioned. The Task Force was cautioned that although residential treatment works better where there is high denial, there are additional stresses in being separated from family and community.

> Troubled employees are quick served in a treatment facility outside the context of their problem, under pressure, with no real follow-up or even re-integration, and they create further local demand when they relapse. Families can only be included on a local basis. Results of a shortsighted quick fix perception are costly to industry, and human beings suffer.
> **W. Mundy, Prince George**

> What might be perceived as follow-up by a residential treatment centre would be perceived as treatment by outpatient service. It is important to understand that changing a long term habit pattern is a long term process. People can't be sent off to be "fixed". In a residential treatment program an individual is not exposed to all of the triggers that have been operating for them and they will need to cope with these when they return home. An outpatient clinic on the other hand assists people in dealing with these triggers on a daily basis.
> **Beth Chamberlain, Outpatient Clinic, Prince George**

> The advantage of the [outpatient treatment] approach is that the individual can still remain close to his or her family and his or her work thereby avoiding a sharp transition from institution back to the "real world". Support and assistance from family members can be incorporated into the active treatment process.
> **Manual for EAP Referral Agents, Health and Welfare Canada**

> Research to date comparing inpatient with outpatient treatment has resolved neither which is most effective nor the extent to which effectiveness depends on predisposing characteristics of patients and the nature of their problems.
> **Drinking Problems/Walsh and Hingson**

On the other hand, several presenters felt that there was a shortage of residential beds in some areas of the province and that some groups were under-serviced.

> The client often must wait months to enter a residential treatment centre.
> **ALMACA**

The following chart compares the costs of the different components of treatment to the client and to the Province:

Comparative Cost of Services

	Average Cost to Province per Admission $	Per Diem Cost to Client $	Average Length of Stay (days)	Average Total Cost to Client $	Average Cost to Province and Client $
Detoxification	264	-	2.5	-	264
Outpatients	668	-	-	-	668
Supportive Recovery Home	563	16	24.0	388	951
Residential Treatment	1736	16	29.3	475	2211

The figures show that residential treatment is relatively expensive, underlining the necessity for accurate, expert and thorough evaluation of patients before referral. There is also a wide variation in the cost of treatment between individual treatment centres. Therefore, the subject of treatment cost should be included in the recommended study.

The Task Force heard repeatedly throughout the province discussions of poor communications between certain residential treatment centres and the referralagents, such as outpatient centres. Some residential treatment centres were criticized as being unresponsive to the needs of both the referral agents and the patients, that the centres had become isolated, inflexible and authoritarian. The Task Force was told that this was reflected in the occupancy rates for certain treatment centres. In other words, some treatment centres in the province have long waiting lists whereas others had low bed occupancy rates. Thus the problem would appear in British Columbia to be not necessarily a lack of beds, but rather an uneven utilization of existing beds.

The Residential Treatment system should receive careful study with special emphasis on the needs of referral sources to determine treatment bed requirements. There is a need to eliminate long waiting lists at outpatient clinics, which cause referral sources to bypass them, thereby creating increased demand on residential centres.

Specific skills are needed in the centres for the care of health care professionals.

> British Columbia is facility rich but at the same time woefully understaffed and underfinanced and extremely short of psychologists. At the present time many health care professionals are sent to residential programs outside of the province. There is a real need in British Columbia for residential programs which have a necessary skill and expertise to deal with this peculiar group of patients and who also have adequate follow-up networks for these people after residential treatment.
> **Dr. John Dick, Chairman, Impaired Physicians Program Committee, British Columbia Medical Association.**

The Medical Practitioner

The special relationship that can develop between doctors and their patients provides an excellent climate for intervention in the chemical abuse/addiction process. With dismay we learned that many Task Force submissions placed the medical profession squarely in the role of enabler - not only failing to recognize the illness but contributing directly to the chemical dependency by supplying prescriptions ultimately abused by the patient.

It appears that few physicians have the clinical, psychological, psychiatric, counselling and medical training necessary in order to identify, assess and treat the disease with the third highest mortality rate in Canada.

Until recently, doctors completed four years of medical training, plus a one- or two-year internship, without coordinated instruction about the disease. There is no question that they studied the individual diseases caused by chemical dependency and which form the manifest *symptoms* of the disease. But probably at no time was the disease of chemical dependency (alcoholism) taught in the coordinated manner necessary to have a solid grasp on the myriad, complex and diverse facets of the illness.

The medical profession has chosen to view the disease process of alcoholism with the same collective denial as the remainder of Canadian society. In that regard they are no different than the alcoholic who denies the alcoholism...the spouse who denies the partner's problem...the employer who denies a worker's chemical dependency....the union that continues to defend an employee with a drug-induced problem...the professional association denying that individual members of their group could have the illness. All of those denials are in the face of documented, delineated evidence, yet attempts to confront and tackle the problem have been few.

Beyond the issue of lack of training, little personal or professional satisfaction comes from dealing with an alcoholic patient who never appears to get better but returns frequently with repeated physical illnesses, has apparently insoluble emotional and personal problems and uses manipulation, anger, aggressiveness and denial as the primary manner of interpersonal communication. The time expended detracts from the time the physician can spend with patients who would appear to wish to cooperate in resolving their problems.

The physician who has special training and experience in treating the chemically dependent understands the concept of the disease entity; recognizes the symptoms for what they are; understands the manipulative-aggressive personality; and deals with all of those appropriately by attempting some form of intervention and treatment; and yet the professional relationship can still remain difficult.

Successful treatment begins by bringing the problem to the attention of the patient and the family. Collective denial must be identified and addressed. The patient must undergo detoxification under supervised conditions and arrangements must be made for a proper assessment of the patient and the family. Treatment alternatives must be arranged and explained, and long term problems must be coordinated and supervised. In short, the time commitment necessary for successful intervention by the physician is enormous and out of proportion compared to treatment of any other disease entity.

Many physicians face a dilemma when deciding to deal with drug dependency cases. The time it takes to intervene properly can be prohibitive in terms of monetary reimbursement. In British Columbia, doctors bill on a fee-for-service basis under their contract with the Medical Services Plan of British Columbia. The contract clearly delineates what fees can be charged for various services and places restrictions as to which type of services are paid for by the Medical Services Plan, even in some cases how often the fee items may be charged. A detailed history and examination (half-hour or longer) can only be billed once in a six-month period. Counselling sessions of 30 to 40 minutes can be charged four times in a calendar year per patient.

Few physicians, even those properly trained and motivated, can afford to deal with problems of such complexity, requiring such longterm emotional commitments and be reimbursed so inadequately, without being further burdened by a sense of frustration.

When physicians recognize that they have neither the training nor the time and choose to send the patient to the local ADP office for assessment and counselling, further frustration ensues when an appointment is not available for at least four weeks due to excessive demands placed on counsellors. The physicians then have a choice: attempt to solve a problem they do not feel qualified to deal with or risk losing contact with the patient and therefore lose the initiative, perhaps never to regain it.

Prescribing Practices

It was the opinion of a counsellor from the interior that doctors did not see themselves in the role of addicting their patients; however, it was felt that some of them became lazy about their prescribing habits, didn't care or were ignorant about the drugs they were prescribing. The counsellor found "doctor prescribed addicts" difficult to treat.

Factors identified as leading to the over-prescribing of prescription drugs:

-A physician from Vancouver, in a personal submission to the Task Force, said: "All physicians have been taught that their job is to help, to cure illness and to relieve suffering." He felt that, at times, mood-altering drugs were prescribed because "... there did not appear to be an alternative for the physician to help."

-The "manipulative patient" or people who "... appear to be able to convince a physician that they needed a mood-altering drug." If not successful, the patient may choose to leave; the physician will be aware that the illness is unlikely to be dealt with; another physician will easily be found to prescribe the desired medication.

-The prevalent practice of renewing prescriptions through a telephone call by the physician to the pharmacist, without having seen the patient professionally.

-Some choose the "easy way out" rather than risk offending and losing a patient.

-The inappropriate prolonged prescribing of a formerly appropriate analgesic for chronic pain when it is vital to reassess the continuing need for potent analgesics.

A Vancouver physician observed: "There are more legal addicts in our society than illegal."

To avoid the potential dangers of prescription drugs people must be taught to be more discriminating consumers, asking questions of their doctors about all prescriptions. A change of attitude is necessary to get away from the idea that there is a "pill for every ill". However, slick media advertising makes that change a formidable challenge. The concept that it is reasonable to turn to chemicals to help solve personal and emotional problems or to help with relaxation must be disavowed.

Self-Help Groups

Alcoholics Anonymous

In British Columbia most small communities have an AA group meeting weekly. That this approach works is almost a truism. Based on the principle of anonymity, it helps the alcoholic to accomplish something he or she cannot do alone - stay sober and improve quality of life. The Task Force heard repeated support for AA, which may be underused by referral sources.

Al-Anon Family Groups

Many presenters praised this free, successful resource for families and friends of alcoholics. It is based on the 12 steps of AA and can be found in communities throughout the province.

Alateen

These free, effective groups grew under sponsorship of Al-Anon, specifically to support teenagers in alcoholic homes.

Narcotics Anonymous; Cocaine Anonymous

Allied in no other way with AA except for permission to use their 12 steps - the rules upon which AA was founded, they are found mainly in major population centres in the province.

Adult Children of Alcoholics

Increasing public awareness and the success of this relatively new group (developed within the last 10 years) has led to its rapid growth; groups meet in most major centres.

With AA as the prototype, the self-help groups form an essential, invaluable resource for those whose lives are affected by chemical dependency. The Task Force feels that an extremely important part of any related professional service is ensuring that patients and their families become involved with the appropriate self-help group.

EDUCATION

Schools

The use of education and information as tools in the prevention of substance abuse was a consistent theme in presentations. For education to fulfil a preventive function the instruction must occur before the onset of drinking and drugging.

> I also feel that the education of our workers in alcohol and drug abuse should start long before they are in the workplace. I believe it should start as early as possible, have all children learning as they advance and go through our schools...educate them...so they know the consequences before they get involved. Coming through the school system...I remember very little information being available...on such matters.
> **Peter Dowd, Apollo Forest Products**

Mr. Dowd's comments are representative of the widely held perception that there is an urgent need for additions to the public school curriculum relating to alcohol and drugs and that this key element in prevention is scarcely being tapped. Mr. Art Steinman, Alcohol-Drug Education Service, suggests that alcohol and drug abuse should be an integral part of a comprehensive health education program, with the status of an academic subject in its own right.

Several presenters commented on the content and philosophy of such programs, referring to the need to educate the students in the nature of alcohol and other drugs, the problems they may face using such substances, and the development of skills necessary for making positive lifestyle choices.

The importance of helping students develop skills in thinking before making major decisions in their lives is implicit in the "Making Decisions" program of Alcohol-Drug Education Service of Vancouver, now being used in schools in many areas of the province.

> I believe strongly in the value of the Making Decisions program. There is no preaching involved. Instead, the program aims to create awareness...it is also very useful because it helps deal with peer pressure - a major problem for lots of kids....
> **John McCormick, Lake Cowichan**

Although the following observations were directed to peer counselling in the workplace, the Task Force believes the cautions delivered by Dr. Carr are equally applicable to the education of our youth.

> We are concerned that approaches which focus primarily on providing information about drug and alcohol problems often look attractive and manageable. But years of research show that warnings stressing negative consequences or other such "educational" approaches has not had a significant impact on the reduction of abuse...our view is that if we are to improve the effectiveness of substance abuse education, we need to take a more social, psychological approach and work on programs that involve decision making, thinking and assertiveness (learning how to say "no" to drug abuse for example).
> **Dr. Rey Carr, University of Victoria**

Alcohol advertising makes an impression on children, even if unintended. Art Steinman gave the example of students in grade 2 being able to complete the words of a beer ad and identify the product after hearing the first two lines sung to them. There is a need, he said, for students to be taught what the ad is not telling them about the use of alcohol. There is a need for critical thinking.

The academic message must be reinforced through the example of a visible policy on substance abuse consistently applied throughout the school system. Students spend much of their school time in structured activity, supervised by professionally trained personnel. Both behaviour and educational performance are regularly monitored. Students with alcohol and drug problems are recognized by teachers, counsellors and school administrators. They must not be ignored. The EAP concept, applied to schools, would result in a student assistance program to which troubled students could turn on their own initiative, or be referred as a consequence of observed and documented alcohol or drug abuse, or continuing unsatisfactory performance as a student.

Competing and conflicting demands for classroom time for various topics is an ongoing problem. Some resistance to expansion can be expected. The objectives of the school program can be defined provincially but its implementation will require support and cooperation at the local community level.

General Public

The use of alcohol to levels of intoxication resulting in significant impairment remains socially acceptable in virtually all situations except where someone's personal safety becomes at risk.

Many presenters blame the social acceptance of alcohol abuse as a major factor obstructing addiction prevention efforts. They called for a comprehensive program directed at changing this public perception and social acceptance.

Society's perception of mood-altering substances must be changed, through information programs (advertising, instruction courses etc.) on addiction, prevalence, effects on families and children and social costs. This will require a long term commitment, strong leadership and effective coordination.

Business and Labour

The prime education message to management is two-fold: First, no organization is immune to alcohol and drug abuse by its employees; second, there is an effective way to manage the problem: the EAP process.

Unions must instruct their representatives that alcohol and other drugs have both short and long term dangers to their members. Casual use on the worksite causes impairment, creating a safety hazard to self and others. Habitual use anywhere leads to addiction. Casual use on the worksite can be prevented through peer pressure. Chronic abuse can be prevented through the EAP process.

All organizations require a clear, consistent policy on substance abuse applicable to every employee regardless of position. There is no such thing as "social" use of alcohol or other drugs on the worksite, whether that site be the forest, the kitchen, the factory or the boardroom.

Associations

Professional groups, unions, service clubs, religious organizations and political groups have great influence on setting the standards of behaviour of the community at large. These associations could be used as vehicles of transmission in attempts to educate the public at large.

WORKERS' COMPENSATION BOARD

Alcohol, Drugs And The Worker

The abuse of alcohol and other drugs can have two possible effects on workers and their relations with the WCB. The first possibility is impairment, when that impairment is part of the contributing factors leading to an injury. The second occurs when alcohol and drug abuse impede recovery.

In the first case, alcohol and other mind altering drugs impair judgment or coordination, making the worker more likely to have an injury. An often repeated American statistic is that the chemical abuser is five times as likely to file a workers' compensation claim. If that statement is true, it follows that an analysis of Workers' Compensation Board data should uncover a group of workers with multiple injuries much in excess of the norm.

In the second instance, there must be a certain percentage of claimants whose recovery is abnormal, where the healing process is delayed beyond expectation, or fails to occur at all, even with relatively minor injuries.

Multiple Injuries

A computer review was conducted on all claimants reporting a claim since July, 1974. If a claim was reported, the computer counted all of the claims reported in that claimant's lifetime, going back prior to July, 1974 as required. In that period of almost 13 years, 1,130,181 claimants reported 3,367,362 claims. The claimants' lifetime history is as follows:

CLAIMANTS WITH ONE OR MORE CLAIMS

NO. CLAIMS PER CLAIMANT	NO. CLAIMANTS PER CATEGORY	CUMULATIVE % CLAIMANTS	NO. CLAIMS PER CATEGORY	CUMULATIVE % CLAIMS
1	529,084	46.81	529,084	15.71
2	200,054	64.52	400,108	27.59
3	114,358	74.63	343,074	37.78
4	75,030	81.27	300,120	46.69
5	52,263	85.90	261,315	54.46
6-10	114,204	96.00	850,727	79.72
11-15	30,593	98.71	383,103	91.10
16-20	9,388	99.54	165,081	96.00
21-30	4,397	99.93	105,055	99.12
31-40	648	99.99	22,053	99.77
41-50	128	-	5,678	99.94
51-60	24	-	1,290	99.98
61-70	8	-	520	-
71-80	1	-	71	-
81-83	1	-	83	-
TOTAL	**1,130,181**	**100.00**	**3,367,362**	**100.00**

Almost half of the claimants had only one claim. About three out of four had three claims or less. Less than one out of five had more than four claims.

Only four claimants out of a hundred had more than 10 claims, yet these multiple injury workers were responsible for every fifth claim, 20.28 percent of all claims. There are 45,188 workers in this minority group. Between them, they accounted for 682,934 claims.

The above table counts claimants only and gives no information on workers who were claim free since July, 1974. Thus, although the 45,188 workers who had more than ten claims represented four percent of claimants, they would represent a smaller percentage of the total work force.

The claims reported were "lifetime" claims. Obviously, there is an age factor in "lifetime" claims. It could be expected that the older the worker, the more likelihood of multiple claims.

Some industries are more hazardous than others. It could be expected that workers in "hazardous" industries would have a higher claims frequency than workers in other non-hazardous industries.

During a trial period, March 23 to May 1, 1987, a hand controlled record was kept on new claims where the claimant had at least 25 previous claims. The claimant's age, number of previous claims, and industry classification were recorded. We have added the 1987 basic assessment rate as a rough indication of the "hazard" of the industry:

NEW CLAIMS
WHERE CLAIMANT HAD AT LEAST 25 PREVIOUS CLAIMS
MARCH 23 - MAY 1, 1987

AGE	NO. OF PREVIOUS CLAIMS	INDUSTRY CLASSIFICATION	BASIC ASSESSMENT RATE
59	27	070710	3.12
49	30	070705	3.12
50	30	070724	3.12
63	32	070705	3.12
46	36	010501	3.31
36	27	070705	3.12
47	27	070701	3.12
56	26	010200	8.11
39	25	060412	3.00
54	36	070621	5.53
34	33	065900	1.69
38	30	063703	2.85
38	34	070701	3.12
30	27	070714	3.12
34	26	065900	1.69
52	26	070709	3.12
59	30	072102	5.44
52	31	010200	8.11
32	34	010502	3.31
39	25	070705	3.12
40	26	010900	7.95
43	27	062600	1.65
50	28	070701	3.12
59	30	070707	3.12
46	35	060236	2.15
40	27	070200	3.00
57	30	010200	8.11
38	42	070600	5.53
29	32	070701	3.12
56	27	085100	4.27
33	41	140100	1.50
54	65	065900	1.69
42	32	070701	3.12
64	26	062600	1.65
32	29	070705	3.12
44	40	063201	3.30
47	30	063700	2.85
43	30	043000	1.17
45	37	070719	3.12
41	30	090100	3.26
31	28	010700	2.43
39	32	070705	3.12
53	25	070600	5.53

Multiple injury claimants are spread across several classifications. They appear in both high and low risk industries.

The youngest claimant in the sample accumulated 32 claims in a lifetime of only 29 years. If the claimant started work at 18 years of age, then the frequency rate is almost 3 claims for every working year. In contrast, the oldest claimant had 26 claims in a lifetime of 64 years, an estimated frequency rate of slightly worse than 1/2 of one claim a working year. In the sample, the record claimant had 65 claims in a lifetime of 54 years, an estimated frequency rate of almost 2 claims per working year.

The average claimant has had less than 3 claims in their working lifetime. What factors cause a few workers to have as many annual injuries, year after year, as most have throughout their working lifetime?

The Task Force believes that "luck" has very little to do with an injury occurring. Except for the extremely rare "acts of God", an injury occurs as a result of an unsafe condition, act or procedure or any combination of those factors. The element of luck may influence the severity of the injury, but generally is not an appropriate causative factor of the injury itself. For example, if a truck leaks oil on a garage floor and a mechanic slips on the oil and falls, there was no "luck" in the accident happening. An unsafe condition, the slippery floor, was the causative factor. Having had the accident, the mechanic would be "lucky" if he did not injure himself, or if he received only minor injuries. He would be "unlucky" if he received a serious injury.

A worker does not accumulate a history of multiple claims because of bad luck. Multiple claims are the result of continuing unsafe conditions, habitual unsafe acts, constant unsafe procedures, or any long term combination of those factors. The causative factors may be occupational or personal.

Occupational factors include all elements that can be controlled by the employer. By regulation, the employer is responsible for the "maintenance of safe premises and operations". The employer is specifically required to maintain safe work conditions under regulation 8.04:

> All buildings, excavations, structures, machinery, equipment, tools and places of employment shall be maintained in such condition that workers will not be endangered.

The employer is required under regulation 8.08 to:

> Ensure that regular inspections are made of all places of employment. . .and work methods and practices. . . at intervals that will prevent the development of unsafe work conditions.

Regulation 8.10 requires the correction of unsafe conditions:

> Whenever a person observes what appears to be an unsafe or harmful condition or act he shall report it as soon as possible to his supervisor or to the employer. The person receiving the report shall investigate the reported unsafe condition or act and shall ensure that any necessary corrective action is taken without delay.

The employer also has a responsibility for the workers' safe performance of their duties. Regulation 8.18 requires:

> Every employer shall ensure the adequate direction and instruction of workers in the safe performance of their duties.

It appears that any employer of workers with a history of multiple claims is in technical violation of the above regulation; their direction and instruction of those workers in the safe performance of their duties has been inadequate.

Supervisors also share the employer's responsibilities, as stated in regulation 8.20:

> Every supervisor shall be responsible for the proper instruction of workers under his direction and control, and for ensuring that their work is performed without undue risk.

The employer and the supervisor are required to gauge a worker's ability to work safely and to withhold work assignments when an impairment is suspected. Physical and mental impairments are to be controlled by the enforcement of regulation 8.28:

> Workers with physical or mental impairment shall not be assigned to work where such impairment endangers themselves or others.

Workers impaired by alcohol, drugs or other substances are to be controlled through the enforcement of Regulation 8.30:

> No person shall enter or remain or be permitted to remain on the premises of any place of employment while his ability to work is so affected by alcohol, drug or other substance as to endanger his health or safety or that of any other person.

Impairment is not a black or white condition. There are many shades of grey; there are many degrees of impairment. The last two regulations are readily enforceable when dealing with gross impairment. The staggering, falling down drunk, reeking of rum, is easily identified and can be removed from the worksite. The known, visibly impaired worker should not be assigned a task requiring a high degree of visual acuity. The difficulties of enforcement increase as the gross signs of impairment decrease. Nevertheless, the difficulties of enforcement do not absolve accountability; worksite impairment properly remains an employer responsibility.

However, worksite impairment is a shared responsibility. Regulation 8.30 applies directly and personally to the impaired worker. Alcohol and drug abuse are personal factors that lead to impairment, that leads to endangerment, that leads to injury. Emotional and physical problems are also personal factors that may lead to impairment, endangerment and injury.

Personal safety of the worker is both a right and an obligation. Under regulation 8.24 the worker has a responsibility to refuse to carry out a work process when there is "reasonable cause to believe that to do so would create an undue hazard to the health or safety of any person". Following orders does not absolve responsibility.

Improper personal conduct is forbidden under regulation 8.34:

> No person shall engage in any improper activity or behaviour that might create or constitute a hazard to himself or any other worker. For the purpose of this regulation, improper activity or behaviour includes "horseplay", scuffling, fighting, practical jokes, unnecessary running or jumping or similar conduct.

All of those regulations are of a preventive nature designed to avert an injury. Section 6 of the regulations deals with post injury "accident reports and investigations". Regulation 6.04 (3) defines the intent of an investigation:

> An accident investigation shall, as far as possible, determine the cause or causes of the accident, shall identify any unsafe conditions, acts or procedures which contributed in any manner to the accident and shall develop recommended corrective action to prevent similar accidents.

Causative factors exist for all injuries. If the factors are occupational, the employer is responsible for corrective action. If no occupational factors are found, then the possibility of personal causative factors must be suspected. The greater the number of personal injuries without occupational causative factors, the more certain it becomes that the causative factors are personal. The main personal causative factors are alcohol or other drug impairment, emotional or physical problems, or any combination.

The purpose of determining whether the causative factors are occupational or personal is not to allocate blame. That would be non-productive. The purpose is, as stated in the regulations, "to develop recommended corrective action to prevent similar accidents".

Occupational factors can be eliminated or reduced through corrective action by the employer, perhaps in cooperation with, or at the direction of, officers of the WCB.

Personal factors can be eliminated or reduced through corrective action by the worker. Alcoholism, other addictions, emotional and physical problems are all treatable illnesses or conditions.

Workers with a history of multiple claims will tend to continue having claims until corrective action is taken. A multiple claims worker is in a condition of undue hazard regardless of whether the prime causative factors are occupational or personal.

It is reasonable to assume that multiple claims tend to have a cumulative impact on a worker's health and well being, that each successive claim is potentially more serious as traumas overlap or exacerbate pre-existing conditions. A multiple claims worker whose "luck" runs out, could receive a crippling or fatal injury. A multiple claims worker is at risk and is in need of help. Intervention is required.

Delayed Recovery

The Chairperson of the Workers' Compensation Board of Manitoba, Ms. Sonny Arrojado, speaking to a 1985 conference on Rehabilitation and Re-employment, stated:

> It is generally accepted in compensation circles that 10% of time loss claims represent approximately 90% of the total costs of compensation. Therefore, it is reasonable to conclude that the system's focus should be on the identification of the potential 10%, and the commitment of its resources to minimizing the time loss and the "disabilities" that can result from this group.

The British Columbia WCB confirms the general truth of Ms. Arrojado's statement, acknowledging that a small percentage of the claims account for a major proportion of the total costs. It was pointed out to the Task Force that catastrophic injuries, such as severe burns, spinal cord injuries and lost limbs are not the major factor; their severity is more than offset by their low frequency. It is the minimal incident or injury that has a disproportionate disability and delayed recovery that generates the high costs.

The Journal of Occupational Medicine, November 1983, in the article entitled, "Delayed Recovery In the Patient With a Work Compensable Injury", described the process:

> Let us consider the sequelae that frequently occur with the difficult patient. Initially the physician does not suspect that this patient will have a delayed recovery. He evaluates the patient following a compensable injury, treats him according to accepted medical practice, and writes the patient a release, excusing him from work. Somewhere in the course of the patient's physiological recovery, the physician begins to notice that something is amiss. While the patient's clinical picture improves, his complaints of pain and/or disability do not. The physician becomes concerned that he is missing some additional medical problem; he orders more tests, consults with specialists, and continues to keep the patient off work. He may also notice the development of functional components in the course of the patient's physical examination, and as each test is found to be negative and as other physicians can find nothing extraordinary, the physician begins to suspect. . . . The doctor tends to withdraw from the patient's care. He may write a report. . .stating that the diagnosis is not clear or that the problem is functional or non-organic. Although the patient is so labelled, no treatment is recommended. Eventually, the patient might be referred to some physician who feels that the patient might be helped by some surgical procedure. The patient is not made better by the surgery, in fact he becomes worse. Eventually a disability claim is filed..." .

Ms. Arrojado also relates the process of failure:

> . . . Another role the attending physician may take is a gradual but definite retreat from the active medical management of the patient. This usually happens when all the medical investigations reveal no objective medical evidence to support the contention of ongoing disability. It is extremely rare to find where the necessary psychological and motivational supports are recognized and initiated by the attending physician in the early phases of the disability. Referral for appropriate action, if it occurs, usually happens late, and when it does occur the claimant is already settled into a new occupation . . . Disabled . . ..

R. Michael Cannings, Assistant Director, Vocational Rehabilitation Services, British Columbia WCB, agrees with early intervention. He said, "Early involvement of the Rehabilitation Consultant can often avoid the development of a chronic disability syndrome by providing appropriate individual counselling. The primary goals of early intervention are avoidance of medical abuse and maximization of the benefits to be obtained from the physician's recommendation."

One form of medical abuse is the inappropriate, prolonged prescribing of addictive medications by the attending physician. According to Dr. David W. Florence, in the August 1979 issue of "Legal Aspects of Medical Practice", ". . .the single most costly component of the medical aspect of workers' compensation stems from the inability of the physician to differentiate the physical and emotional problems and deal with each adequately." Dr. Florence stated:

> Physicians, too often, are manipulated by a Compensation patient because they react passively to such suggestions as "Doctor, I need a few more weeks off" . . . the doctor, not looking for more strife in his life, . . . will often take the easy way out and comply with the dominating patient's request for more time off, extra rest, and additional physiotherapy. . . not to mention the continuation of addictive medications. The phoned prescription is usually the most effective mechanism for keeping the annoying compensation patient out of the office. Many addicts are made or perpetuated by this short-sighted system.
>
> Whether we as physicians realize it or not, we are frequently the enablers, the perpetrators of the disabling process. Because of what we do and don't do, people are permanently crippled. . . both physically and mentally.

Those comments are echoed in the previously quoted article, "Delayed Recovery in the Patient With the Work Compensable Injury." Drs. Derebery and Tullis stated:

> Under certain circumstances, patients who are receiving compensation for illness or injury will have a disproportionate disability and a delayed recovery. . .such patients cause a tremendous financial burden to society, can be very frustrating for the physician to treat, and can be very resistant to treatment.
>
> As early recognition is imperative, successful treatment of such a patient requires that the physician has a high index of suspicion when dealing with a compensable injury of any kind. Chronicity in compensable injury cases should be considered psychogenic unless the failure to recover can be clearly explained as the normal response to the physiologic insult.
>
> The problem is also propagated by a widespread medical practice of prescribing additional rest and inactivity for the patient who is experiencing a delayed recovery following a musculoskeletal injury. This is particularly common when dealing with low back injuries, which account for 35% of compensable disabling injuries. The physician, who may not recognize that the delayed recovery is primarily due to psychological factors, often succumbs to pressure from the patient. . . . This results in an unhealthy situation in which the patient governs the physician's medical treatment. . . .Keeping the patient off work not only leads to a general physical weakening, but also may have adverse psychological effects, such that the patient may perceive that his injury is more severe and disabling than it actually is.
>
> The employee's emotional well being and personality will greatly influence the response to trauma. For example, if a patient has a strong unconscious desire to be taken care of and significant dependency needs, he may well resist recovery from his injury.
>
> When evaluating the patient who is experiencing the delayed recovery or who has a disability that is disproportionate to his injury, one must determine if the primary problem is physiological or psychological.
>
> As soon as the physician identifies a delayed recovery, or when he is experiencing difficulty returning the patient to work, he should arrange to take a comprehensive history which will serve him in uncovering the primary problem. . . . Is he taking pain medication that might be contributing to depression? Is there a history of drug abuse or alcoholism?
>
> Bed rest should be kept at a minimum. For example, most back injuries, including those with suspected herniated discs, only rarely require more than several days of bed rest. Bed rest results in rapid disuse and atrophy, a decrease in the sense of well being and a general catabolic state.
>
> Use of narcotics following most musculoskeletal injuries should be restricted to no more than one to two weeks at the maximum. Long term use of these drugs is detrimental, decreasing the patient's tolerance

> to pain, affecting mentation and exacerbating depression.

Ms. Arrojado commented on the non-assertiveness of the worker in the course of treatment. She described them as being "the passive recipients of whatever cure and information that the attending physician chooses to provide. It is not unusual to find people who would normally be assertive and inquisitive reduced to the role of an automaton when dealing with their doctor. " Assuming that her statement is true for a certain percentage of workers, and further assuming that the level of medical incompetency described in the articles quoted above applies only to a certain percentage of physicians, it can be concluded that there is a very real risk when these two groups meet during the course of an injury. The risk will be greater if the worker already has a problem with alcohol or other drugs. The prescription of pain killers and/or tranquilizers may push the worker over the edge, decreasing tolerance to pain, affecting the thought process and deepening existing depression.

The WCB of British Columbia have recognized that alcoholism could be a factor in an injured worker's return to work. Section 86.50 of their Rehabilitation Services and Claims Manual refers to "Multiple Problems":

> Where the worker is suffering from a work injury together with some other impediment to his return to work (e.g. alcoholism), rehabilitation assistance may sometimes be needed and provided to cover the whole problem.
>
> But where the return to work of a worker is not being impeded at all by a compensable injury, and he simply has some other problem, such as alcoholism or an unrelated disability, rehabilitation assistance should not be provided or if being provided, should be discontinued.

For this section to apply, there first has to occur a recognition that there is a "multiple problem", that there is an impediment to recovery in addition to the injury. Ms. Arrojado described the difficulty of the early identification of cases of delayed recovery:

> The bulk of the potential problematic 10 percent is composed of those cases which were initially reported as strains and sprains.
>
> To my knowledge, there is no system in Canada which has effectively incorporated objective identification criteria of the potential problematic 10% into their respective claims/medical process during the period when injured workers are on total temporary disability benefits. Internal referral of the injured worker to the systems rehabilitation service usually occurs many months after the initial injury and by this time other factors have been superimposed on the situation which makes the probabilities of a successful rehabilitation dim.

Ms. Arrojado speaks of "other factors". The WCB Rehabilitation Services and Claims Manual refers to "multiple problems". The Task Force believes that the most common "other factors" and "multiple problems" are likely to be alcohol and other drug abuse, emotional problems as a prime disease, or as sequelae to alcoholism and addiction, and physical problems resulting from addiction. All of these are treatable illnesses or conditions.

We have been advised by the British Columbia WCB that it is rare for a worker experiencing a delayed recovery to have had only one or two claims. It is possible that multiple injuries and delayed recoveries are both symptoms of a common cause. If so, at the start of a new claim, a history of multiple injuries may be useful as a "red flag" warning of the possibility of a delayed recovery. A second "red flag" warning could be the claimant's own history of recovery in prior injuries. If any claim has resulted in extraordinary time loss that cannot be explained by the injury itself, it could be expected that any new claim will also be extraordinary. Further, such a pattern may continue until the root cause of the delayed recoveries is identified and treated.

Intervention

In an ideal situation, the worker with a history of multiple injuries and/or delayed recoveries would be employed by a company with an effective safety program and a "broad brush" Employee Assistance Program (EAP). In this ideal situation, either as a result of the accident investigation process, or through an analysis of the worker's overall safety record, the possibility of personal problems as causative factors would be considered and referrals made to the firm's EAP. Regardless of the nature of the personal problem or the method of entry into the program, qualified help would be available, the prime problem would be identified and treated. The worker would no longer be at risk. The worker would recover to maximum potential.

The Task Force suspects that relatively few multiple injury workers incurred their record of injuries while continuously employed by a firm with an effective safety program. The terms "multiple injury worker" and "effective safety program" are almost mutually exclusive. It is more likely that most multiple injury workers have worked for different firms sharing their injuries among them, with each new employer being unaware of the worker's injury history. In the alternative, if the multiple injury worker established the injury record entirely at one employer it must be concluded that the employer does not "keep score" or, if records are kept, simply is not motivated to act.

In the first instance, when a firm hires a multiple injury worker, the lack of knowledge of the injury pattern will leave the employer vulnerable to a continuation of injuries. Their "direction and instruction of workers in the safe performance of their duties" will prove inadequate if unknown personal causative factors contribute to more injuries. It would probably take at least two additional injuries before a pattern of risk could be established by that firm and the process of corrective action begun. The multiple injury worker would remain at risk during the firm's window of vulnerability.

Multiple injury workers employed by firms that don't "keep score" or "don't care" are in continuous risk. It doesn't matter if the causative factors are occupational or personal. The firm has not taken corrective action in the past and is unlikely to do so in the future unless there is some outside motivation to do so.

SOLUTIONS

The EAP Concept

EAPs are a process, a system of action leading from the identification of a problem, through intervention to assessment, via referral to treatment. In a workplace the chain of events is triggered by unsatisfactory job performance. An offer of help is made in recognition that job performance can deteriorate because of severe personal problems. A potential human need results in an offer of help, a humane response enhanced by the employment relationship.

The EAP concept is valid. EAPs are the most effective means to combat alcohol and drug abuse in the workplace.

The Task Force believes that the EAP capacity to help is transferable to communities other than the workplace. We go through life as members of different communities. We are, or were, part of a family; part of the student body in learning institutions; part of political, municipal or social bodies. We have been unified by common interests in a religion, a profession or a trade union. In each of those communities we have had shared responsibilities and tasks. When we do not meet our responsibilities or the standards of a particular community, it can be said that our task performance is unsatisfactory. If that community had an assistance program for its members, the unsatisfactory performance could trigger a form of intervention, leading to assessment, referral and treatment.

We have a community in common as citizens of British Columbia.

The Task Force recommends that the EAP concept be extended so that its services be available to all citizens of the province whose task performance may deteriorate because of alcohol or drug abuse or any other severe personal problem.

To achieve that goal it is also recommended:

1. a) That the present name of Alcohol and Drug Programs be changed to a more general title such as Community Assistance Program (CAP) and that it be designated the following functions:

Assessment and Referral Service
Alcohol and Drug Programs
(Treatment function)
Prevention
Education
Research

Recommendation of the title "Community Assistance Programs" is for the purpose of the report only but the use of the word "community" is important to convey the broad scope that the program should achieve.

One of the objectives of assistance programs is to promote and encourage self referrals. Denial is activated by the name "Alcohol and Drug Programs". A troubled individual may be willing to seek help for the stress of a failing marriage, subconsciously denying that alcohol abuse is the cause of the marital problems. That same individual is unlikely to go to Alcohol and Drug Programs for help.

The Task Force was convinced that Alcohol and Drug Programs are probably attracting less than half the number of people who would come for help if the name were changed.

At present, even the referral process is handicapped by the ADP name. The Task Force was told often that the supervisor has to detect and document unsatisfactory work performance but is not supposed to diagnose the nature of the problem. A referral to an ADP, even for assessment, is a form of diagnosis.

The title "Alcohol and Drug Programs" is appropriate only for treatment of alcoholism and other addictions, not for the assessment and referral service that it provides for other clients.

Community Assistance Programs - The Organization

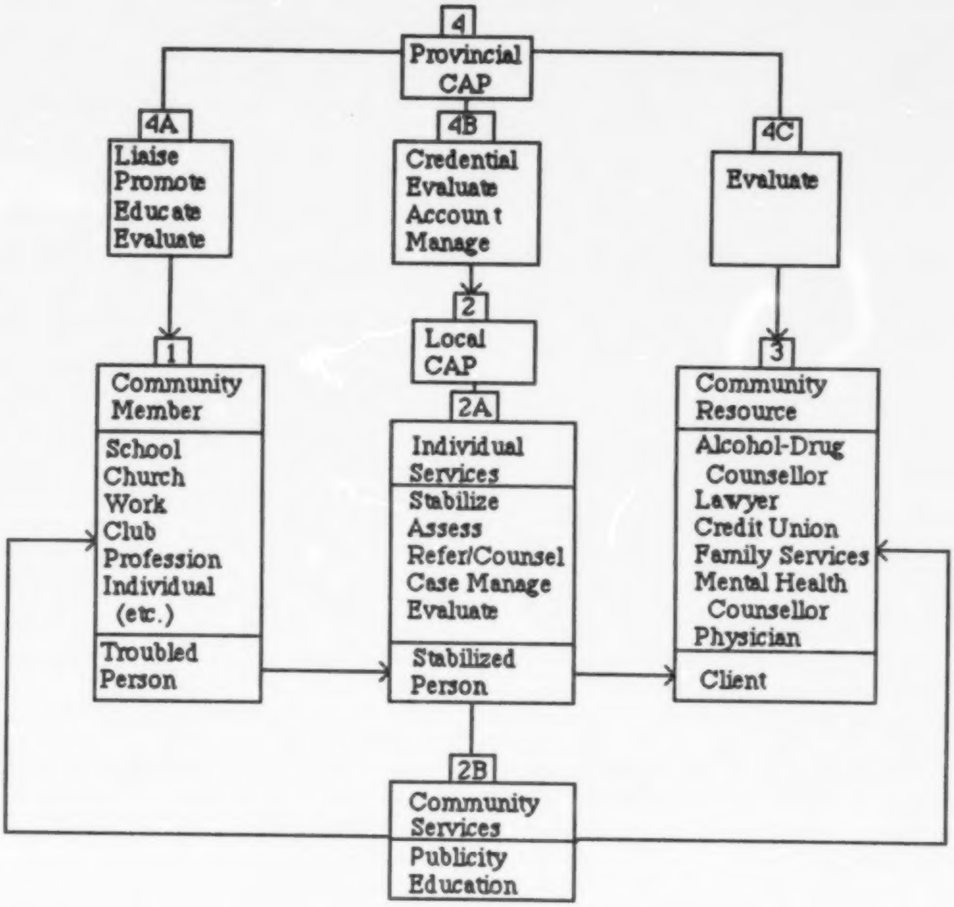
The program would be administered by the provincial CAP.

The primary goal of the provincial CAP should be to make all individuals and groups aware that anyone troubled with chemical dependency or other severe personal problems can get help through the local CAP service - by self-referral or through the encouragement and intervention of others.

Local CAPs would be the link between community members and community resources.

Personnel in local CAPs would refer troubled persons to the most appropriate treatment resource and would promote the use of the Program through developmental work at group and individual levels.

This chart outlines the relationships within the system.


4
Provincial CAP
4A
Liaise
Promote
Educate
Evaluate
4B
Credential
Evaluate
Account
Manage
4C
Evaluate
1
Community Member
School
Church
Work
Club
Profession
Individual
(etc.)
Troubled Person
2
Local CAP
2A
Individual Services
Stabilize
Assess
Refer/Counsel
Case Manage
Evaluate
Stabilized Person
3
Community Resource
Alcohol-Drug Counsellor
Lawyer
Credit Union
Family Services
Mental Health Counsellor
Physician
Client
2B
Community Services
Publicity
Education

(1) The Community Member

Every community is composed of a number of constituents or members. Community members may belong to one or more of the following groups:

- a family
- a school
- a church
- a workforce
- a service club
- a professional association
- a consumer group

etc.

Troubled community members may use their local CAP service either by self referral, or by being encouraged through the intervention of others.

(2) The Local CAP

The CAP acts as a link betwen the community member and the community resource. Community members are referred by the local CAP to the most appropriate treatment resource in the community.

Each CAP worker must be a skilled and professional assessment counsellor. Ideally, there should be several CAP workers in a community so that all potential problem areas may be properly assessed.

Each CAP is based in its community, offering individual as well as community service.

(2 A) Individual Services

Stabilization...
To meet the immediate needs of an individual in crisis and provide other personal services once stability has been achieved.

Assessment...
To determine appropriate action and seek client's agreement and cooperation concerning treatment.

Referral/Counselling...
When agreement is reached on referral to the appropriate community resource, the CAP worker and the client may also agree to short term counselling (dependent on the CAP worker's skills and availability of suitable resources).

Case Management...
To continue contact and, where necessary, act as liaison between the client, community resources and other community members.

Evaluation...
To determine the degree of success achieved and the quality of community resources.

(2B) Community Services

Each local CAP will undertake outreach or developmental work to encourage use of the resource, using promotion and information services and providing education and training on intervention for special interest groups or individuals.

(3) Community Resources

The local CAP will call upon available community resources depending on their level of service, skill, professionalism and appropriateness.

(4) The Provincial CAP

The provincial program will:

(4A) Provide community members with liaison, promotion services and education; get their feedback on the value of their local CAP services.

(4B) Certify local CAPs; evaluate their services; administer financial activities with regard to reimbursement of local CAP staff.

(4C) Conduct or coordinate evaluation of community resource services; receive feedback from those groups about the quality of local CAPs.

The existing ADP would become the nucleus of the proposed CAP. The ADP title would be retained to

apply only to personnel and facilities concerned with treament of alcoholism and other addictions.
The assessment and referral services of CAP would become key functions. It is expected that most assessments will confirm alcoholism or drug abuse, leading to referrals to treatment through ADP, so a close connection between the two services is desirable.

ADP personnel have received praise throughout the hearings. It makes sense not to disrupt the employees or the organizational structure, which can set the pattern for future growth. Many of the treatment services provided throughout the province are funded agencies; their personnel are not employees of the Ministry of Health. In a similar fashion, the assessment and referral services of CAPs can be provided by contracted local agencies.

l.b) That CAP ensures that appropriate services are available to all citizens of British Columbia, regardless of location, gender, age, occupation or financial status.

Location
Assessment and referral services must be made available to small communities.

Demand for the services will vary with population. Because remuneration would be fee-for-service, a CAP agent might not be able to sustain a livelihood at lesser population levels unless the service was an add-on to an existing occupation or profession.

A form of assessment and referral is already provided in the small communities, through the medical doctor. Two factors could lead to MDs assuming the role of local CAP agent: first, specialized training in the field of chemical dependency and, second, financial incentive.

The Task Force recommends that this solution be pursued throughout the province - in cities as well as smaller centres. Once a physician is accredited as a CAP agent, all time spent on those services would be billed to CAP.

Anyone with proper training and the necessary skills could be accredited as a CAP agent. Existing EAP services could respond to the public at large following accreditation.

Gender
Unlike men, women with chemical dependency are more likely to be misdiagnosed as having bad nerves, depression or other emotional ailment. And too often the misdiagnosis leads to inappropriate prescribing of tranquilizers. The prime illness remains undetected; the prescription leads to dual addiction.

Education programs and material are essential in this area. EAPs must address the needs specific to women employees. Public education must help to change judgmental attitudes to reduce the social stigma imposed on those women.

There is an urgent need for increased awareness about the dangers of alcohol and other drug use during pregnancy; about the dangers of tranquilizers used to solve social and personal problems.

Women whose worksite is their home will not have an EAP to guide them into treatment. Their present path to recovery is through self-referral. The Task Force believes that more women would come to a Community Assistance Program than choose to attend the present addiction specific agency, Alcohol and Drug Programs.

Current programs can be modified to be more sensitive to women's issues. Choices and options can be provided for women clients such as women counsellors, women-only therapy groups and treatment for sexual abuse survivors. There should be a strengthening of the existing service network for women, including day care and residential programs for pregnant women or those caring for small children.

Age
Children can be alcoholic and addicted to other drugs. As their illness progresses there will be increasing problems at home, school and in the community.

The family is usually the first to notice but the seriousness is often denied or not recognized.

The community begins to pay the price when the impaired behaviour turns unlawful. Vandalism, theft and other offences lead to juvenile court. Without treatment of the primary problem, aberrant behaviour will likely continue into adulthood. When they have a family of their own, the children are faced with a society they are ill-equipped to handle. *(Refer to Appendix 1: Letter from Jim L., a recovering alcoholic.)*

The steps of rehabilitation can be initiated in the family setting, the school system and the courts. The parents are key players. They must learn how to intervene themselves or, alternatively, their role in assisting intervention by others.

Intervention in the school system could be part of a "Student Assistance Program". The EAP concept could be easily adapted to the classroom.

The Task Force recommends that a Student Assistance Program become part of a standard policy on alcohol and drug abuse developed by the Ministry of Education and that any type of personal problem affecting student performance could be addressed through the program.

Intervention by the courts, at the earliest possible age, is advisable. Since treatment results are reported to be equal for voluntary and involuntary patients, it should be mandatory for those identified.

Treatment may take the form of outpatient counselling, live-in treatment centres and involvement with self-help groups such as Alcoholics Anonymous. Children and youth present special difficulties. Many counsellors will be unable to break through the generation gap. Without true, two-way communication, treatment will surely fail. There is a need to develop a group of counsellors who are effective in working with the young. Such specialization is also required in a treatment centre setting.

The Task Force also acknowledges the special needs of the retired. The senior population is partially composed of people leaving the workforce. Pre-retirement education in the workplace concerning the stresses of retirement and resources should be available.

Seniors facing difficulties tend to have complex problems, one of which may be chemical dependency. There is a great need for better intervention methods and also for skilled professional assessment and referral to appropriate resources. Specialization in counselling may be required.

Occupation

Employee Assistance Programs are available only to a minority of the workforce in British Columbia. Most are in large, unionized organizations. In medium-sized firms, their application is minimal. In small business, they are almost non-existent.

EAPs can relieve pain and suffering, improve the quality of life and save jobs. The difference between working for an employer with an EAP and one without can be that of treatment or illness, hope or despair. The difference can even be a matter of life or death for the alcoholic.

The Task Force believes that the potential benefits of an EAP should be available to all workers. Professional help to relieve personal problems should not depend on being "lucky" enough to work for an employer with an EAP.

Government can encourage employers to establish formal EAPs by creating an environment in which they could flourish--through the recommended Community Assistance Programs (CAPs).

The five elements of an EAP process are identification, intervention, assessment, referral and treatment. Identification and intervention are the employer's responsibility. Assessment and referral require specialized knowledge and expertise, which can be provided through accredited, CAP agents. Treatment would be provided through various community services, as it is now.

Generic education materials could be made available to employers, to teach them how to identify and intervene where necessary. On request, advice and counselling from CAP agents or CAP personnel would be offered to employers, unions and individual workers, as well as anyone interested in implementing an EAP.

The Task Force believes that assessment and referral functions require specialized knowledge in chemical dependency, wide knowledge in other personal problems and skills in assessment. It is unrealistic to expect small business and medium sized employers to be able to afford to retain such an expert on staff. It is recommended that assessment and referral services be made available to employers through CAP agents and, where necessary, through CAP personnel. It is also recommended that the policy of no fee for outpatient counselling be continued. Neither the employer nor the employee should be charged for this service.

As more and more EAPs are developed, the demand for treatment services will increase. The Ministry of Health must be adequately funded to ensure that treatment providers are able to respond effectively.

CAP would alleviate some of the impediments to the maximum utilization of EAPs:

-the use of accredited external third party CAP agents for assessment and referral would improve quality control and lower overhead costs;

-use of local CAP agents for assessment and referral in firms with multiple worksites, would ensure a high standard of service at no additional cost to their EAP budget;

-availability of accredited, external third party CAP agents knowledgeable in a wide range of personal problems in addition to their specialized training in chemical dependency, would provide users with a "broad brush" approach;

-the use of external third party CAP agents would avoid the problems inherent in on-site premises. The program would be more likely to be used, the users more able to preserve their anonymity;

-the use of external, third party CAP agents would lessen the chance of conflicts-of-interest between regular duties and EAP responsibilities for those wearing two hats. People with a crisis could be referred directly to the external CAP agent during the absence of the individual responsible for the corporate EAP. A crisis would not have to be put "on-hold";

-in larger organizations the use of third party CAP agents for assessment and referral would give the EAP practitioner more time to serve the needs of the corporate client. As observed earlier by Arlene Keis, "...an EAP's effectiveness is in direct relationship to the effort and time put into the organization work...";

-provision of educational and promotion materials would minimize developmental costs for the new EAP. Start-up advice and counselling would also be available from CAP and CAP agents.

In spite of such incentives many workers will still be employed by organizations without an EAP, unable to benefit from the informal and formal referrals of the intervention process. However, as a citizen of British Columbia, they should be entitled to participate in a Community Assistance Program through the means of a self-referral to CAP or a CAP agent.

Financial Status

Of the treatment services funded by Alcohol and Drug Programs, only residential treatment centres have a direct cost to the client; detoxification and outpatient counselling have no user fee.

For the unemployed receiving social assistance, all treatment is free of charge.

High wage earners usually can afford the *per diem* costs and often have time away from work covered through a sick leave plan.

The working poor can afford neither the direct *per diem* costs of residential treatment nor the indirect costs of lost wages. Residential treatment is beyond their economic reach. They can obtain residential treatment services only by changing their economic status, either through the good fortune of obtaining a better paying job or, paradoxically, through the misfortune of losing their job. Since we are talking of the working poor alcoholic or the working poor addict, it is most likely that the change of economic status will occur negatively, with the loss of job.

The St. Patrick's House survey determined the high costs of chronic alcoholism. Hospital and medical costs, UIC and welfare benefits, treatment, legal and justice costs averaged $24,000 per year over the drinking lifetime of the group studied. Such costs can be averted by encouraging treatment at the earliest possible stage of the illness. Successful treatment benefits both the individual and the community as a whole.

Treatment can be encouraged by making outpatient counselling more accessible to the working poor by offering the service outside normal working hours. Off-hours counselling, combined with participation in self-help groups such as AA could prove to be an effective and complete program leading to successful rehabilitation. There would be no cost to the client.

For others, residential treatment services may be required. Inadequate personal finances should not be a barrier to the residential treatment of a working poor alcoholic. It is recommended that special financial assistance such as grants or forgivable loans be made available to complete the course of recovery.

1.c) That CAP have greatly enhanced research functions and capability.

There is a need for a coordinated and standardized collection of information from numerous agencies that have gathered statistics on alcohol and drug uses.

Hospitals
B.C. Coroner's Service
Insurance Corporation of British Columbia
Workers' Compensation Board
Coordinated Law Enforcement Unit
Ministries of Health, Education, Social Service and Housing, Transportation and Highways
Alcohol and Drug Treatment Societies
Federal Bureau of Dangerous Drugs

The information and its interpretation are essential to effective program development policy and planning. There is a need for expert design of practical research projects.

1.d) That CAP, in consultation with the relevant professional associations and the Ministry of Advanced Education and Job Training, develop standards for accreditation for those working in the field of chemical dependency.

Mr. Chris Bitten of ALMACA presented convincing arguments for the need of credentialling in the EAP field. His comments are equally applicable to everyone working with chemically dependent people: "There comes a time when it is necessary to determine what knowledge and competencies are essential to satisfactory practice, what the components of a good [program] are, and what the parameters of the profession are."

The Task Force agrees and recommends that the Ministry of Health, through Community Assistance Programs, in consultation with the relevant professional association, develop standards for accreditation for those working in the field of chemical dependency.

To ensure quality control it is recommended that accreditation be a prerequisite to becoming a contracted local CAP agency.

1.e) That CAP, with the medical profession, develop an accreditation process for physicians participating in the CAP process.

Physicians are an essential element of the CAP system. To participate, interested physicians will need to receive training. CAP, together with the University of British Columbia, Faculty of Medicine, must develop an accreditation process.

There is no recognized sub-specialty of medicine addressing the addictive process, however, the American Society on Alcohol and Other Drug Dependencies Inc. has established an examination process which was given for the first time in Los Angeles in 1986. Several physicians in the province have successfully completed those examinations. Their expertise should be sought when developing the accreditation standards. A second group of physicians forms a larger but equally valuable source of advice: alcoholic physicians in recovery who have lived with the problem of alcoholism, have faced their addiction and dealt with its issues on a daily basis.

Because alcoholism and other drug related disorders are under-diagnosed, they remain untreated and their medical sequelae are responsible for a disproportionate percentage of the province's health care costs. Changes should be made in medical education so that primary care physicians have the necessary knowledge and skill to effectively recognize, intervene with and refer to appropriate services, those suffering from, affected by, or at risk of developing chemical dependency.

The following suggestions are made with respect to teaching in medical schools:

1) The disease of chemical dependency (alcoholism) should be taught in a block or holistic manner, in a coordinated, multi-disciplined approach.

2) Instructors should be recognized experts in the subject and should include:

-those with special training in drugs and alcohol:
    -physicians;
    -psychologists;
    -psychiatrists;
    -social workers;
-other medical specialists;
-representatives from AA and similar support groups;
-professional alcohol and drug counsellors;
-members of the clergy with alcohol and drug experience.

3) Besides having practical and didactic content, the course should include bedside experience and individual and group counselling.

4) The course should be given over the four years of medical school, each year's content following logically from the previous year, with added complexity of participation and responsibility.

5) All aspects of the disease should be included, from histological pathology through the sociological and family aspects, psychiatric and medical issues, and surgical, gynecological and obstetrical problems.

6) Aspiring physicians should learn how to use all related community services; they should become aware of their unique position in the identification, intervention and management of the disease.

7) Attendance at meetings of AA and other self-help groups should be compulsory.

8) All physicians wishing to practice primary care medicine should be required to rotate through an alcohol and drug treatment facility.

2. That the recommendation of the Liquor Policy Review, June 1987, concerning Alcohol Education of the Public Licensee and Server and at primary, secondary and post-secondary schools be implemented and expanded to include other drugs.

3. That Fetal Alcohol Syndrome, a common cause of preventable mental retardation, be a prominent subject of continuing education of the public and of the health care professionals.

It is vital that continuing medical education emphasize the importance of fetal alcohol syndrome and how to prevent it and that physicians pass on the information to all women patients of child-bearing potential and pregnant mothers. FAS can be prevented through:

-school education programs;
-repeated public information campaigns;
-direction from primary care physicians; and
-pre-natal clinics.

Adequate training of physicians is urgently required, through medical schools and continuing medical education.

4. That teachers be adequately trained in the recognition of the signs and symptoms of substance abuse and instructed in the proper process and procedure to follow for referring students for assistance.

The performance model of EAPs trains supervisors to be alert to the significance of workers' behaviour and performance. Active monitoring and documentation of unsatisfactory performance are the first steps to intervention.

Teachers are to students what first line supervisors are to workers - and more. The teacher-student relationship is also cerebral. When instruction is given and work assigned, the teacher is trying to reach the student's mind - to capture imagination, to encourage the thought process, to promote new concepts. Chemicals compete with the teacher. Sedatives sedate, stimulants agitate, hallucinogens produce hallucinations. All impede development of the learning mind.

Teachers are in a unique position to detect symptoms of substance abuse. They must be instructed in recognizing the symptoms and the proper procedures for referring students for assistance.

Student assistance programs must be made available to all students in the province through the school system.

5. That local school districts, in conjunction with their provincial association, and in cooperation with teachers' and other employees' organizations develop an Employee Assistance Program for teachers and other employees of public school districts.

Teachers and other employees of public school districts in the province should have an employee assistance program because all parties benefit:

-the troubled person would receive help.
-the school district would have a policy and procedure to deal with unsatisfactory performance in a humane and effective manner.
-the students would receive better quality instruction.

Teachers will have the key role in student assistance programs. It seems just that teachers who have a chemical dependency should receive the same type of assistance they will be providing to their students.

6.a) That the Workers' Compensation Board develop a series of training programs on alcohol and other drugs emphasizing the

techniques of identification of the chemical abuser through signs of use and symptoms of alcohol and other drug dependencies. Such programs should be specifically designed for the use of employers in fulfilling their obligations under Regulation 8.30.

6.b) That the Workers' Compensation Board adapt the Employee Assistance Program concept by establishing a Claimant Assistance Program to enable identification, intervention, assessment, referral and treatment of claimants whose recovery is impeded by alcoholism and other dependencies or other "multiple problems".

6.c) That the Workers' Compensation Board intervene with claimants whose injury history indicates a pattern of undue hazard, determine if the causative factors are occupational or personal and develop recommended corrective action as appropriate.

The Task Force believes that multiple injury workers and delayed recoveries are symptoms of treatable illnesses and correctable conditions. On a collective basis, the large numbers of multiple injury workers and delayed recoveries are merely statistics. On an individual basis they are pain, suffering, crippling injuries and potential deaths. They are human tragedies. If the causes are treatable and correctable the events themselves are preventable. There is only one organization that knows the injury record of all British Columbia workers, and that is the WCB. Since the WCB is the only organization competent to know when intervention is required, it must do so. Failure to be pro-active will enable the problems to continue.

Claimant Assistance Program

The Board and the injured worker establish a temporary reporting relationship during the healing process. The Task Force recommends that the Board use this temporary reporting relationship as an opportunity for intervention in cases of undue multiple claims or delayed recoveries, doing so through the means of a "Claimant Assistance Program".

The same principles, practices and confidentiality that are common to effective EAPs should be replicated in the Board's approach to intervention. The program should be "broad brush" so that problems other than alcohol or drug abuse would be addressed. The program should be advertised to encourage voluntary referrals. A graduated process of informal referrals should precede formal referrals with progression from one stage to the other based on continuing unsatisfactory performance. To ensure confidentiality the assessment and referral function should be carried out by a third party outside the control of the Board.

Need for Consultation

Although intervention may be appropriate for only a small percentage of claimants, the numbers, in real terms, add up to significant case loads. There are over 45,000 claimants with more than 10 claims. There are more than 5,200 with over 20 claims. Claimants with over 25 claims are being reinjured at the rate of 2 per working day, over 500 per year. Ms. Arrojado spoke of 10 percent of time loss claims causing 90 percent of the costs. In British Columbia that 10 percent would be somewhere around 8,000 claims per year. The preventable "delayed recoveries" would be some unknown percentage of the 8,000. The numbers of potential interventions would overwhelm any plan that did not have a means to select priority cases according to need and probability of success.

The Task Force believes that the probability of success of any intervention will vary almost directly with the degree of consultation that occurs between the Board and the employer and the union during the planning and implementation stages of the intervention process. Policies and procedures to guide the program should be developed in cooperation with employer and worker representatives experienced in the EAP process.

Industries vary widely in their occupational hazards, working conditions and standards of safety performance. An injury frequency rate that is normal in one industry could be high in another, or lower than average in a third. The "norms" for multiple injury workers must be based on industry standards. The triggering factor for intervention must be based on a frequency rate that is clearly abnormal and excessive for each particular industry. Industry and labour must be participants in establishing standards of intervention appropriate for that industry.

Pilot projects with supportive and participative companies and worker representatives should test the plan. It is expected that the development of actual cases during the pilot project phase will raise questions on tactics, procedures and policies which would benefit from a tripartite approach to solutions.

Credibility must be earned case by case, company by company. As acceptance grows, the number of pilot projects could be increased. Just as EAPs vary one from another, the Task Force sees the Board's intervention process being tailored to fit participating industries, companies and unions, each with its own standards, each with its own needs.

Intervention

The causative factors of injuries may be occupational, they may be personal, they may be both. Accordingly, when an intervention is triggered by a new claim from a multiple injury worker, the process must involve both the worker and the employer.

It is recommended that a "for cause" worksite inspection be a key function in the intervention of multiple injury workers. The new injury provides the Board with the opportunity to examine the firm's industrial health and safety program as well as discussing the specific issue of the past and future safety of one worker. It is essential for the management of that worksite to realize that the actions of a worker remain the responsibility of the employer even if that worker performs unsafe acts.

Intervention with the multiple injury worker should be educative in nature. The WCB intervention specialist should:

-describe the program in general, emphasizing the positive aspects of identifying the causative factors of multiple injuries so that corrective action may be taken to protect those at risk.

-review the injured worker's claims history with the claimant, detailing why the worker is considered to be at risk.

-explain that help is available to claimants with personal problems when the personal problems are causative factors leading to injury, or are factors impeding recovery.

If there is a possibility of personal causative factors the Board should informally recommend an assessment of the claimant to determine if such factors are a problem and, if so, to have the assessment agency negotiate a course of treatment with the worker. Should the unsatisfactory performance continue, the Board could formally advise the claimant that an independent assessment is reasonably essential to promote the worker's safety or recovery.

Assessment and Referral Agency

It is recommended that the Board always use an independent outside agency for the assessment and referral function. The use of an outside party ensures confidentiality and deflects possible criticism that the Board would be both "judge and jury" of multiple injury workers.

Assessment is required to identify prime problems so that treatment can be effective. The referral function becomes important after the prime problem has been identified. The outside agency's counsellor could also act as a case manager, providing follow-up and interfacing, when necessary, with all concerned parties. In effect, the counsellor could be the overseer of all treatment activities and could often be the only common link between the injured worker, the WCB, the employer, the family physician, the family and the treatment providers.

When making a formal referral, the Board should provide the assessment and referral agency with documentation on the claimant's performance, detailing the history of multiple injury and/or delayed recovery so that their counsellor will have some understanding of the situation. The Board must be open with the referral agent. The reverse is not true. The only feedback expected of the referral agent to the Board is that of the status of the claimant as opposed to the nature of the problem. The status of the claimant refers to whether the individual actually appeared for the interview, is cooperating, and whether referral to a treatment provider has been made. The name of the treatment provider would not be disclosed as such information could be related to the nature of the problem and thus to the content of the case.

Confidentiality

It is recommended that the intervention process be kept away from the claim file. If, during the processing of the claim, an appeal is made by either the claimant or the employer, the whole claim file becomes subject to disclosure. By keeping the intervention process out of the claim file, a measure of confidentiality is achieved.

Intervention files should be maintained under proper security. The files would be claimant-oriented as opposed to claim-oriented. They would contain memos to file concerning the individual meetings with the claimant and/or employer. They would keep track of the informal/formal referral process. They would contain correspondence to and from the outside assessment and referral agency on formal referrals. However, because the assessment and referral agency should be required not to disclose the content of the problem, the intervention files would never contain details of any claimant's personal problems. The only files containing such details would exist at the outside assessment and referral agency and such files would not be subject to disclosure.

Payments

The most desirable situation would occur when the intervention process, including treatment, takes place concurrently with the course of healing of the compensable injury. The claimant would, for example, continue to receive payments from the WCB, even if attending a live-in treatment centre for alcoholism.

Such ideal situations are possible only when the length of recovery of the compensable injury exceeds the time of treatment of the personal problem. This will not likely happen in cases of minor injury when the claimant would be physically capable of returning to work in a relatively short period of time. Nor would it likely be possible in instances of severe personal problems, such as true clinical depression where treatment may take months, if not years.

Alcoholism is not treatable by a quick fix. If, indeed, alcoholism is a chronic life-long condition, it follows that intervention and subsequent treatment are only the first steps in a continuum of care leading to self help on a day-to-day basis. Thus, intervention by the WCB or any third party must be regarded as an act of initiation only. The goal is to start the process; ongoing success is the responsibility of the individual. Accordingly, the WCB should not be held financially responsible for any costs after the normal date of recovery.

Recovery from the injury, in most cases, allows the claimant to return to the employer as an employee ready for work. There would be cases where ongoing treatment would prevent an immediate return to work. The claimant could be two weeks into a six-week treatment centre when recovery from the injury occurs.

The Task Force believes that the responsibility for payments to the individual in such cases belongs to others. If the employer has an EAP, the existing EAP policy should apply. If the employer does not have an EAP but does have a sick leave plan, that plan would apply. If the employer does not have a sick leave plan the UIC plan must apply.

A WCB Claimant Assistance Plan should never, in our view, compete with existing employer programs. If benefits were allowed to continue beyond the normal date of recovery, there would be a form of competition. In many cases the WCB wage loss benefits would be higher than the payments the individual would receive through an employer EAP or sick leave plan. In such cases, the WCB Claimant Assistance Plan would be seen as the preferred plan. There would be a potential for manipulation.

Maintaining WCB wage loss benefits during treatment, while the injury heals, makes economic sense. Two conditions are being treated for the price of one.

Industrial First Aid Attendants

The WCB has an education role to play in the matter of alcohol and drug abuse in the workplace. To ensure that at least one person on most worksites would have an understanding of the problem it is recommended that the WCB modify the curriculum of the Industrial First Aid course to include specific training in the identification of the chemical abuser through signs of use, symptoms of alcoholism and other drug dependencies. It is further recommended that the Board's Occupational Safety Officers be instructed in that portion of the Industrial First Aid course.

First Aid Attendants are certified by the WCB for varying lengths of time depending on the qualification of their "ticket".

Classification	Length of Validity
AA	4 years
A	3 years
B	2 years
C	1 year

Once such a program begins it would take four years to reach all of the Industrial First Aid Attendants in the province. It is recommended that all Occupational Safety Officers of the WCB take the same specialized training as soon as it becomes available.

7. That the recommendations of the Liquor Policy Review, June 1987, concerning beverage alcohol advertising be implemented. In addition, the Task Force recommends that the Liquor Control and Licensing Branch

discourage beverage alcohol advertising that implies a connection with the worksite or depicts alcohol consumption as a rite of passage.

8. That, as recommended by other agencies, e.g. the B. C. Medical Association and the Office of the Chief Coroner, a computerized control system be developed linking all pharmacies.

There is no effective control over the practice of using several doctors deliberately to procure multiple prescriptions for mood altering drugs.

Some patients may innocently consult their family practitioner as well as a specialist and receive duplication of prescriptions; they may receive different prescriptions from each doctor which have the potential for harmful interaction.

There is no comprehensive method for monitoring physicians' prescribing habits.

Data available now on prescription drug use are incomplete and retrospective (e.g. Pharmacare data).

The Task Force was convinced that a computer link-up of pharmacies would provide the needed control.

The system would promote more effective patient management.

Information would be available prospectively to the pharmacist and through the pharmacist to the physician, before the medication is dispensed. The prescribing history would be immediately available and would flag duplication of medications, would warn of potential interactions between medications and would pick up multiple doctoring. As a by-product physicians' prescribing practices could be monitored.

9. That consideration be given to increasing control of "over-the-counter" medications, especially codeine-containing compounds.

10. That funding be increased to the CAP (formerly ADP), to enhance existing services and to initiate additional services in identified need areas.

For the recommendations of the Task Force to be implemented, funding to the Community Assistance Programs (formerly Alcohol and Drug Programs) must be increased from the 1986/87 level of $23.5 million.

The Task Force recommends that an additional $42 million be added to the current Alcohol and Drug Programs budget.

The Task Force recommends that the funds be raised through the sale of beverage alcohol and that they be designated specifically for Community Assistance Programs in addition to funds already committed to Alcohol and Drug Programs.

The case for raising the price on beverage alcohol is compelling. It would generate the needed funds, it would be fair - those at risk would pay, and it would promote health.

FUNDING ESTIMATES

	Current 86/87 Budget $M	Estimated Budget $M
Program Management	1.7	2.0
Prevention	0.5	6.0
Media	0.1	3.0
Laboratory, Pharmacy	0.5	0.0
Research	0.2	2.0
Out-Patient Services	9.7	16.0
Detoxification Services	5.5	7.5
Residential Treatment Services	3.5	4.5
Supportive Recovery Services	1.8	2.5
CAP (Assessment and Referral)	-	12.0
Program Innovation (Ward Teams etc.)	-	3.0
Education and training	-	7.0
TOTAL	**23.5**	**65.5**

The funding estimates attempt to quantify the financial response required to implement or enhance the following:

-Primary prevention activities will be directed at reducing the possibility of substance abuse developing. Secondary prevention will minimize the damage if it does develop. Tertiary prevention will prevent further damage and resotre health.

-Media campaigns should increase public awareness of all facets of substance abuse including the way to get help.

-Research is required to improve the capability of prevention and rehabilitation techniques.

-Out-Patient Services are the cornerstone of treatment and will remain so in the future. The CAP program will increase demand for their services substantially.

-Detoxification in a safe, supportive environment is becoming more important as the incidence of poly-drug addiction rises.

-Residential Treatment Services require specialization to meet the needs of population sub-groups.

-Supportive Recovery Services also require specialization to meet the needs of population sub-groups.

-CAP (Assessment and Referral) is the service that makes the EAP capacity to help available to all citizens of the province.

-Program innovation encourages pilot projects.

-Education and training is directed at both users and providers of CAP services.

APPENDIX I

The following is a letter from a recovering drug addict.

My Name is Jim L I am a recovering Drug addict.

I guess like anything else the easyest way to start is in the beggining. I always seemed to have a problem fitting in or feeling a part of. I feel it all started when I was growing up my family moved around alot. I'd gone to approx. 10 different schools before I hit high school. It seemed everytime I had a set of friends we'd up and move so I felt very insecure.

By the time I started high school I knew I was looking for something but I didn't know what. I had my frist drunk at age 14 - this was what I was looking for. As a friend of mine says I felt 6 ft. tall and the pimples jumped off my face. I liked this feeling it made me fit it made me feel I was a part of. Really it made me not feel like Jim anymore. That was one feeling I didn't like, I never really liked myself, I was always a people pleaser, always wanting to be cool.

The friends I was with started smoking pot so I tryed. It was great. As long as I didn't have to feel like Jim anything was great. Pretty soon I graduated to harder drugs ex. acid, MDA, mushrooms, cocaine. Anything except Heroin, to me if you put a needle in your arm or did heroin you were an addict. One thing for sure, I WAS NOT an addict. I just didn't like being that boring Jim fellow.

Somewhere in the beginning I lost that Jim fellow and that was fine by me. I thought I was taking drug to be cool, or to fit, or because I enjoyed them. Don't get me wrong, in the beginning I did enjoy drugs, and Alcohol is a drug also. I see today I was using drugs to run from that Jim fellow. I remember at age 16 another drug I wouldn't touch was glue. If you sniffed glue you were scum thats as low as you could go. I remember one day I had no drugs and I just had to have something just a bit to take the edge off. So sure enough I picked up the glue, that was the first and only time I ever sniffed glue. I think the real Jim poped out for a minute, I'd felt really ashamed of myself. Soon I found some more drugs so I shut   that Jim pest out again.

After awhile I started selling drugs at school. After awhile when I turned 17 I got busted. At first I thought I was real cool, I was the first of my friends to get busted.   Everyone was talking about me, I figured I was it.

Then I was doing acid alot. I quit acid for about a week and was just smoking dope and drinking. After a week I did just a little acid and smoked a bunch of hash. It freaked me out, my first bad trip. After that everytime I took drugs I had this freaked out feeling this feeling of impending doom.

So I figured I would just quit drugs not drinking, drinking didn't make me feel that way. I was pretty nieve back then, I figured if you quit you quit. I went through withdrawal, always feeling this impending doom. I thought I was going crazy, so I went to see my family Dr. I told him what was going on, he said take these pills and they'll take that feeling away. They did, those pills were called 30 mg. Serax. I took 6 - 8 or more of those pills everyday for 12 yrs. Those pills controlled my life mentaly, pysickly and spritualy. I knew I wasn't an addict because that was some strung out junkie downtown stealing purses off old ladys, that wasn't me, so I wasn't an addict. I just had a problem with pills. Besides, I tried to justify, I got mine from a Doctor, so I carried on believing one day I'd wake up and everything would be ok.

I think the dumbest thing I ever did was when I got busted. I was sentenced to 3 months in jail, I had been on serax for about 1 year and I went for 3 months without any pills. I still believed that when I got out I could get my pills and life would be great again.

This whole time I was also drinking, I did cocaine once in awhile but it was expensive so I didn't use it that much.

I couldn't even go one day without using , so I used to beat myself emotionally. If I had a Doctor's appointment at 10:00 a.m., I'd wake up at 7:00 a.m. so that I could feel the affects of the pills before I went, just so I could face the Doctor. I remember waking up and reaching for my pills even before my eyes were open.

The order of my life was pills, alcohol, then money, relationships, and myself. God wasn't even in the top 10. I couldn't care about anyone or anything in my life because I didn't care about myself. On the job I would steal. If I hurt my foot at home I would go to work and claim it on compensation, I would be off work for 3 months for an injury that should and did heal in one week. With relationships, I used to beat up my girlfriend, I think the mental abuse was worst than the physical abuse. I just didn't care. If I met someone I hated them, even though I didn't know them.

I couldn't stand being on the pills, yet I was to scared to quit. The end had to be close. People tried to tell me I had a problem, but I really thought that it was them or my family or my job that was the problem. Certainly not me or my pills or alcohol. I felt that if the rest of the world would just be the way I wanted them to be we'd all be ok.

Well I'm not sure what day it was, but it was April of 1985. I had been off work for 3 years on disability, I was due to be cut off disability April 29/85. I went to a supervisor at work (Iwon't mention his name) but I'd dealt with him before, I figured I'd go, listen to his garbage and go back to work. I didn't realize he'd been doing his homework on addiction. He knew something just wasn't right with me. I was sent to the company Doctor who said that physically I was fit to return to work. He asked if I was on any medication and I don't know why, but I said yes.

This supervisor told me that I couldn't go back to work until I was off the pills and had quit drinking. I was devastated. He had asked me, no told me, to give up what I believed was keeping me sane and alive.

I went to my family Doctor who said I could work while still on these pills. The company said they would get a 3rd Doctor and that whatever he said would go. This Doctor was a drug & Alcohol specialist and he knew me as soon as I'd walk in because he had been a practicing addict for a number of years himself. He wasn't about to play my game.

So I had to choose to suffer the pain of withdrawl or surrender to my addiction. I'd come to a point in my life where there was nobody else to blame, my girlfriend had left, she wanted nothing more to do with me, my employer didn't anything more to do with me, and my family didn't really care. I had to look at my situation for what it was. Yes, it was my problem, I created it, nobody forced me to take pills. I knew, that even though I didn't want to quit, I had to or I'd die or go to a nut house or something.

I was introduced to Narcotics Anonymous where I found people who had gone through the same things that I had gone through. There stories were a little different, but the end result was the same. All my excuses and reasonings were just that, excuses. It didn't matter that I just drank beer, or that I didn't drink alone, or before noon, that my pills were legal or I'd never put a needle in my arm. It doesn't matter what you use, or how you use, or how much you use, its why you use. I used my pills for the same reason a junkie puts a needle in his arm, so I wouldn't have to feel.

I still hadn't quit drinking, but that was easy, I just took more pills. I was sitting at a meeting, just about in tears, telling another addict who am I trying to kid, that I can't quit. Then I met Jim again; he wasn't this ugly monster I'd created in my mind. This other addict told me to hang in there it would get better. I went to a detox. I was scared, I was shaking, halucinating, sick, and I was seriously contemplating suicide rather than facing this withdrawal.

I went to a meeting where I met a girl who had been through what I was going through who told me she knew how I felt. I'd been to psychiatrists before, and they told me they knew how I felt and I'd look at them and say to myself, yes, you have read about how it feels, you studied about how it feels, but you have never felt it. Yet something about this girl, I knew that she knew how I felt. I also knew she cared, and for the frist time in as long as I can remember, I felt.

I got one day in clean and sober, it wasn't much, but it meant the world to me, I'd never done it in 15 yrs. of using. I phoned my boss at work and told him that at that time, I hated him. He told me he knew I did and even though he isn't an addict I knew that he understood what I was going through.

I left detox but I had to go for treatment for 3 weeks. Work advanced me some money to stay at a recovery house because I knew that if I went back home I would get loaded again. I wasn't strong enough to be on my own yet. I surrounded myself with other addicts who wanted to stay clean and it helped me.

Today I feel, I care, and I love. I've met Jim and I like him. I can look in a mirror and I don't have to turn away. I don't mind what I see. I also know that I can only keep what I have by giving it away. I approached my supervisor at work with the idea of a recovery house and he was interested in helping me make it a reality. I hated this man for telling me the truth, for telling me what I already knew and didn't want to face.

What do you say to someone who saved your life. Sometimes thank you just isn't enough. So the first way is to stay clean and sober. I know how he feels when he sees me. I believe he knows I know. Its the same way I feel when I talk to someone in detox and I see them in a month or so sharing with another addict. The feeling I get takes me higher than drugs ever did. Today, I do care today, I want to help the best way I can. Someone was there for me, so I'll be there for someone because I want to and I have to I need to.

APPENDIX II

DRUG SCREENING

The issue of drug screening has received much attention since the President of the United States recommended drug testing as a means to combat drug abuse. Urinalysis has been perceived by many as the principal weapon in the war on drugs. To others, drug screening by any method is a violation of fundamental human rights.

The Task Force heard recommendations for and against drug screening. Differences of opinion were often expressed during our open house discussions. Drug testing in the work place is fraught with legal and labour relations pitfalls.

The ethics, legality and appropriateness of drug screening are determined by the circumstances surrounding the test.

Joan McEwen of Davis and Company, in her brief "Alcohol and Drug Abuse in the Workplace, Detection and Response - The Legal Issues", concluded:

> The most significant development [in alcohol and other drug abuse in the workplace] may be the trend away from an adversarial approach to the problem to a non-adversarial approach aimed at early detection, treatment and hopefully successfully rehabilitation of the individual to a productive employ. This preventive approach to employee impairment, supported by a good Employee Assistance Program, which has the support of both labour and management, may well be the best long term solution to this problem.

We agree with Joan McEwen. We believe that a "good Employee Assistance Program, which has the support of both labour and management", is a prerequisite to a long term solution.

Drug screening is a side issue. We have treated it as such in this report. Drug testing is not essential to any of our recommendations.